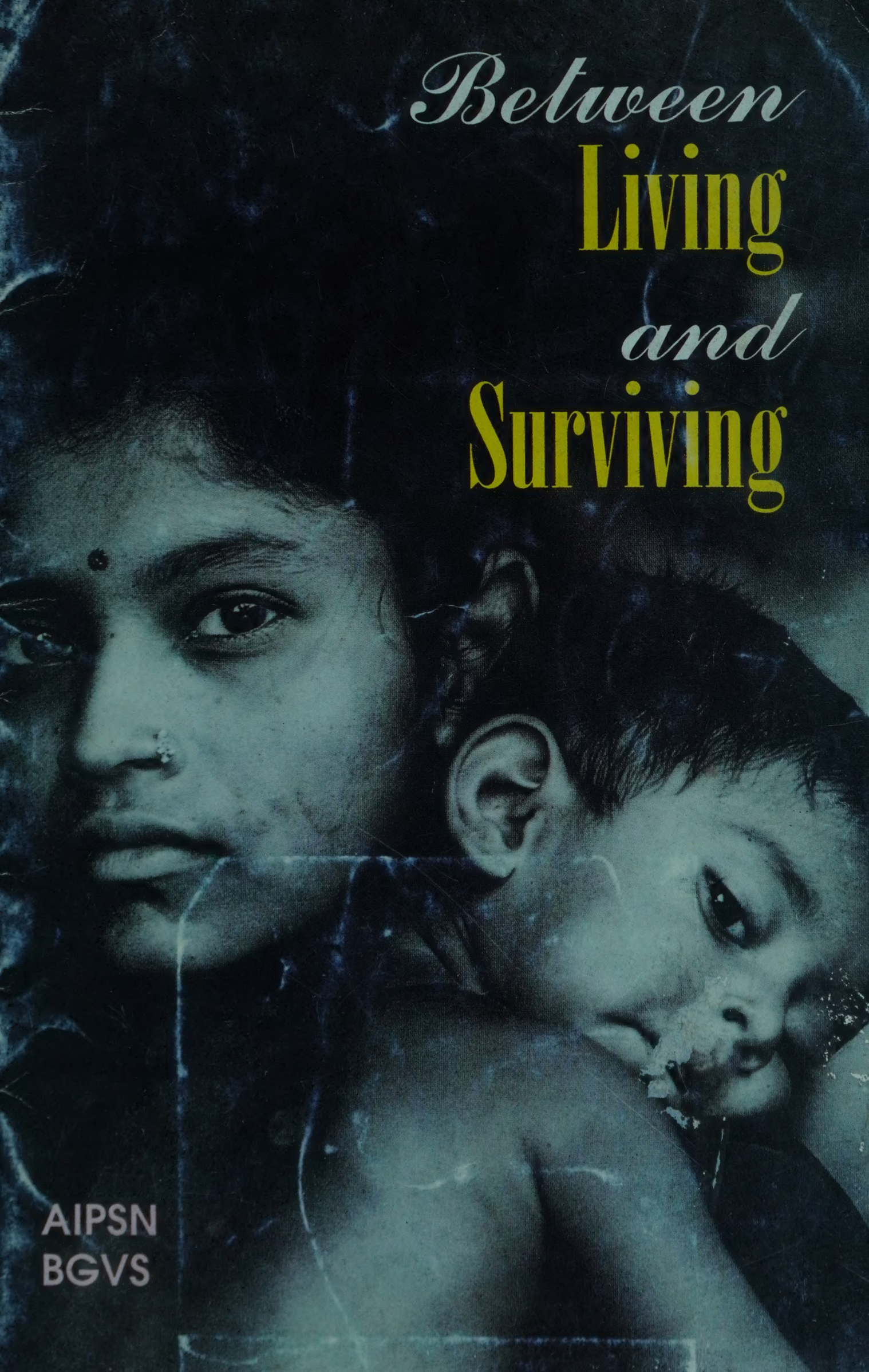
Between Living *and* Surviving



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AUTHOR THE COMMITTEE ON HEALTH OF THE PEOPLE'S SCIENCE MOVEMEN

TITLE Between living and Surviving Health care as fundamentals

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K. Kalpana

Between Living *and* Surviving

HEALTH CARE AS FUNDAMENTAL RIGHT VERSUS HEALTH CARE AS SAFETY NET

WRITTEN BY
THE COMMITTEE ON HEALTH
OF
THE PEOPLE'S SCIENCE MOVEMENTS

A JOINT PUBLICATION OF
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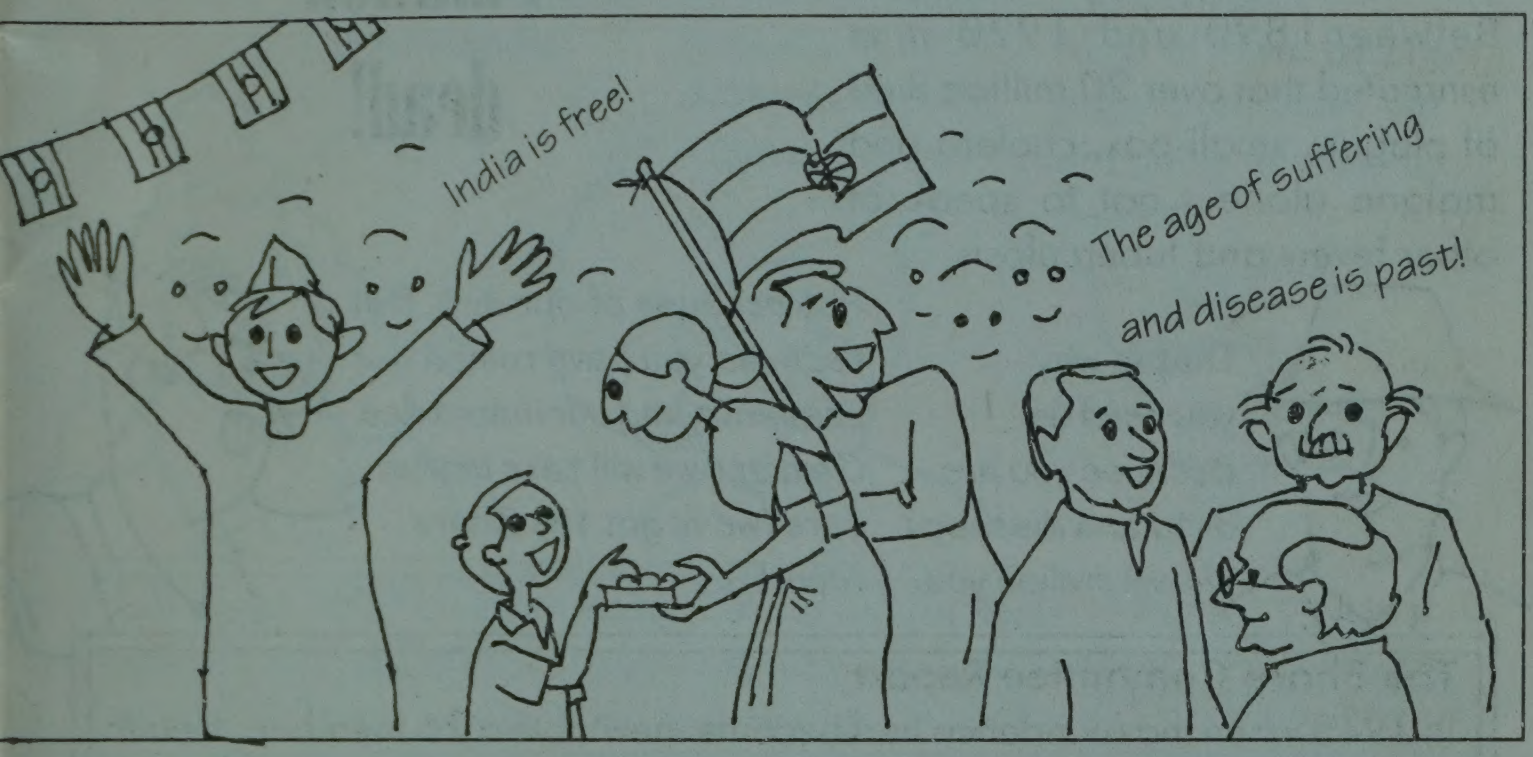
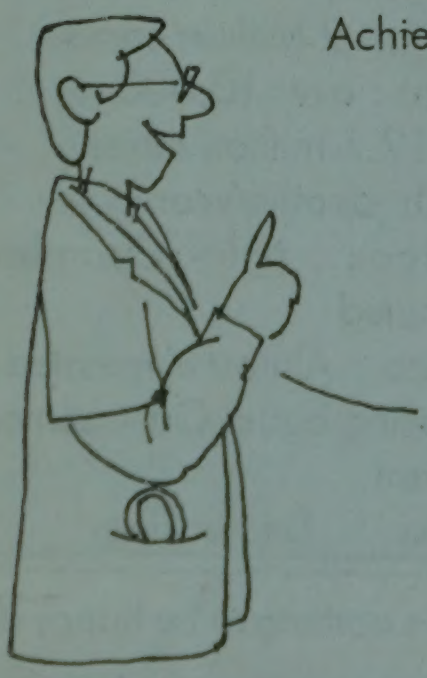
50 Years Ago
There was a Dream



The Bhore Committee Report 18 January 1946

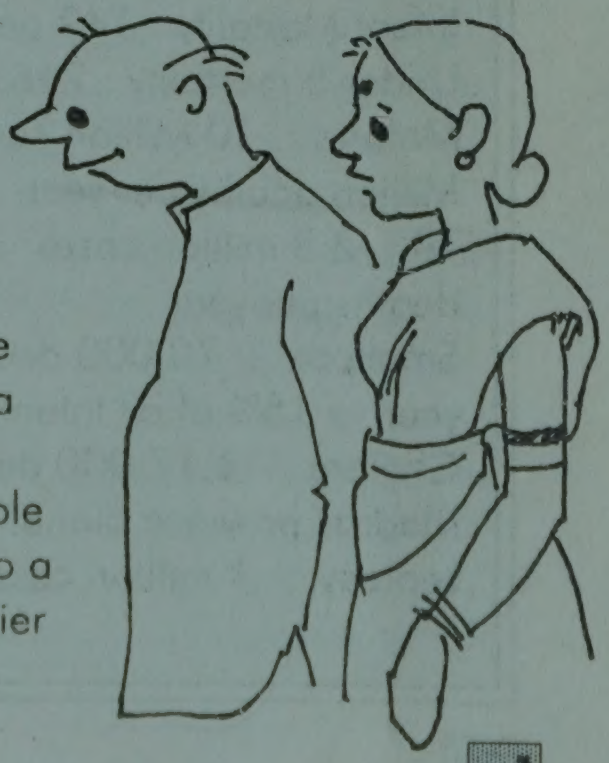
Its main principles:

1. "No individual should fail to secure adequate medical care because of inability to pay for it."
2. The emphasis must be on prevention!
3. Focus on rural areas, with health services,as close to the people as possible
4. Active co-operation of the people in the development of the health programme.



"Total plan to be Achieved in 40 Years"

"The doctor of the future should be a social physician protecting the people and guiding them to a healthier and happier life.



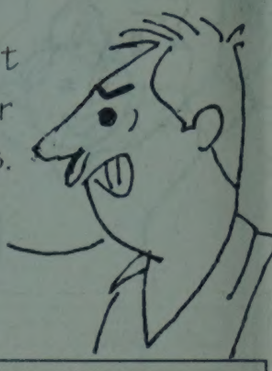
Before Independence

It had been terrible years. Famine and epidemics swept the land. Between 1890 and 1920 it is estimated that over 20 million died of plague, small-pox, cholera and malaria alone - not to speak of other fevers and tuberculosis.

The worst Famine in Indian history:
The Great Bengal Famine :
over
4 million dead!

That is why you need us. Because you are dirty and diseased. We will civilise you.

Not because of our dirt. But because you have ruined our peasants and our industries. Go home we will take better care (we've got the Bhore report!).



The Bhore Committee Report

In 1945 when independence had become inevitable a 26 member `Health survey and Development' committee was set up to recommend a health plan for independent India. Chaired by Sir Joseph Bhore, it later came to be called the Bhore committee report. Its recommendations were revolutionary and were much influenced by the Soviet Union whose experts had helped the committee, Its main principles and recommendations anticipates the `Health for all by 2000 AD' declaration adopted in 1978 at Alma Ata by all the nations of the world.

On Independence Year : 1947.

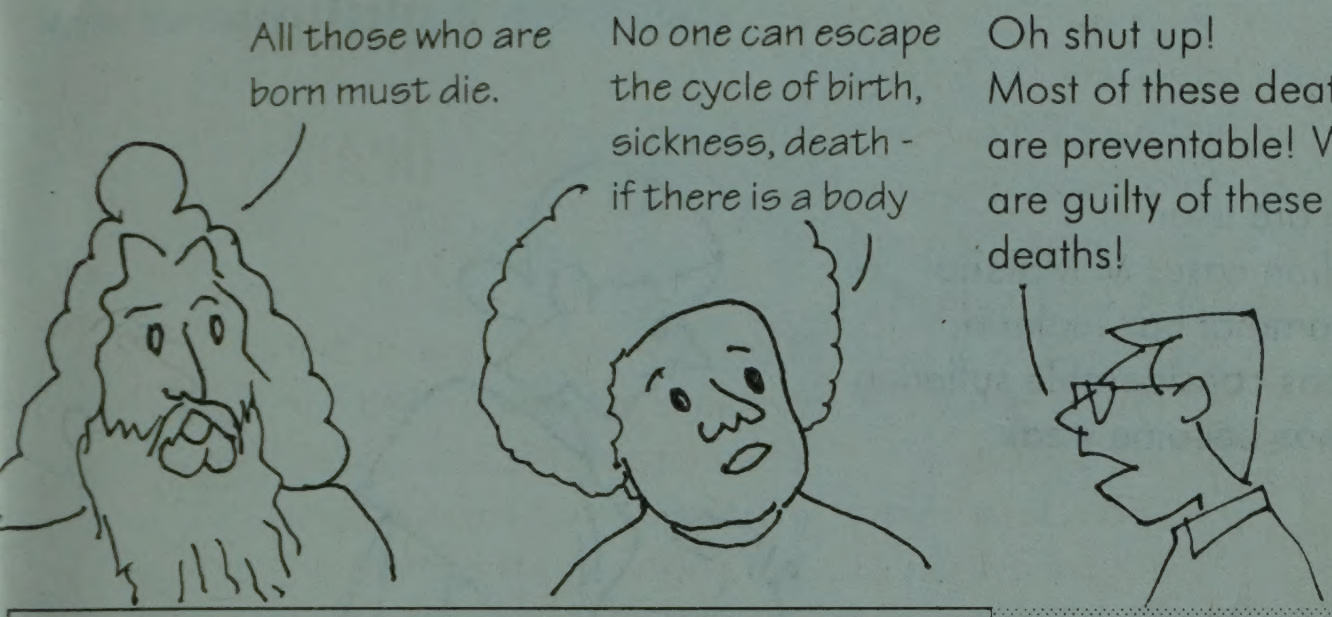
Population : 344 Million
Life expectancy : 33 years.
Infant Mortality : 149 per 1000 -
Under 5 mortality : 246
Malaria : 70 Million cases and 2 Million deaths per year.
TB : 2.5 million cases : 5 lakh deaths per year.
Smallpox : 70,000 deaths per year : 15% of all infant deaths.
Cholera : 1,17,000 deaths in Madras province alone!
Leprasy : 1 million cases.

India Today : 50 years later

Population : 900 million
Life expectancy : 61 years
Infant Mortality : 74 per 1000
Under 5 mortality : 115
Malaria : 9 Million cases
deaths : over 10,000
TB : 12.7 million cases
5 lakh deaths/year
Smallpox : Nil - Completely eliminated.
Cholera : Almost eliminated but now rising again. Gastroenteritis rampant.
Leprosy : Decreasing.

But this is nothing to be happy about.

What do these Statistics mean?



Of every 1000 children born, 70 die before the age of 1 and another 50 die before they reach the age of 5! This is twelve times the rate for UK and about 5 times that of another country like ours - Sri Lanka!

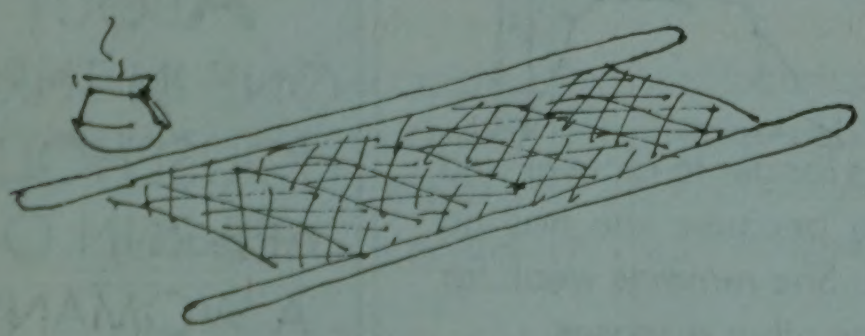
In any of the European countries of every 1000 born, only 10 infants would die.

That is : about 31 LAKH CHILDREN DIED LAST YEAR BECAUSE OF A NATION'S FAILURES!

In every 1 Lakh births, about 510 women in India die!
That is : Every year about 1,48,000 women die in childbirth. Of this about 1,45,000 deaths could have been prevented in a developed country.

In any European country less than 10 women die in pregnancy per 1 Lakh births.

In every year : 5 Lakh persons die of TB and over 9 million cases of Malaria in india : All of it is preventable. We see very little of these diseases in developed countries.
Now such diseases are seen commonly only in third world countries, especially Asia and Africa.

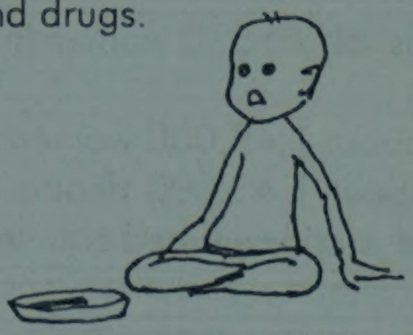


And do you know : This is only talking of deaths. If we take serious disabling diseases into account it would be much more! Thus for every one woman who dies in pregnancy there are 30 who become disabled or chronically ill.

What do these statistics mean?

There are over
9 million cases of Malaria!
Muniammal has malaria.
She has considerable suffering
and has become weak.

But this is not the main worry
If her fever lasts two weeks her loss in wages could be about Rs three hundred.
Moreover she has already spent a hundred rupees to travel to see the doctor and pay for his fees and drugs.



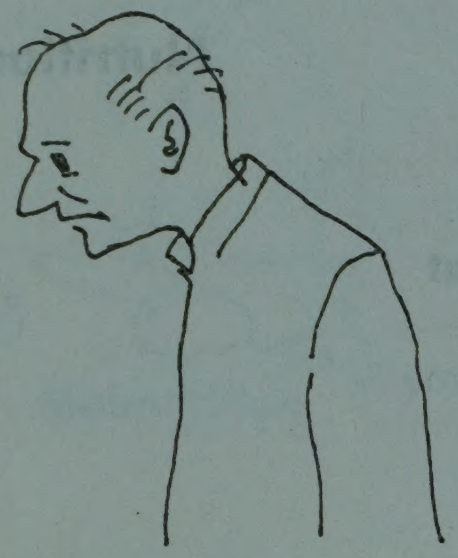
Because she is not going to work she has no money to buy food. She borrows, she gets trapped in debt.
Her children get malnourished. They are sick more often.

Muniammal herself takes longer to recover and recovers less completely because she has no money for her own food. She remains weak for months and prey to many other diseases.
ILL HEALTH MEANS SO MUCH HUMAN MISERY!

ABOUT ONE IN THREE HOUSEHOLDS ARE RUN ON A WOMAN'S WAGE ALONE!

How is a health problem perceived?

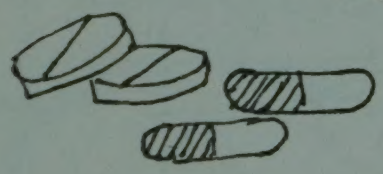
In popular perception in our present culture health is something to do with doctors, diseases and drugs.

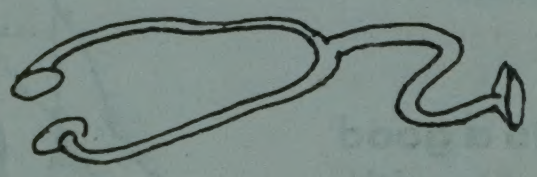


I am ill because I have 'something' called a disease.

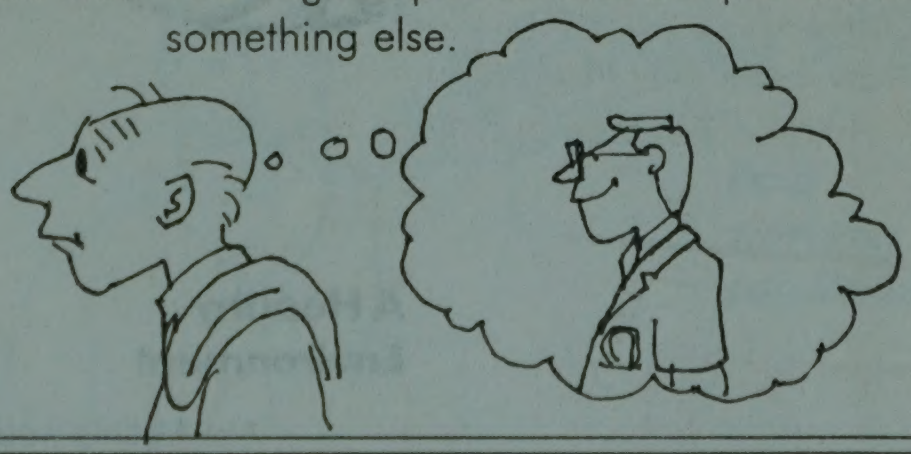
I need to take drugs and injections to get well.

I need a doctor to protect my health and to cure me.





Doctors are essential for diagnosing disease but to think that they are essential to ensure health is mistaken. That would be like saying `it is fire-engines that prevent fires.' Fire-engines put out fires but prevention is something else.



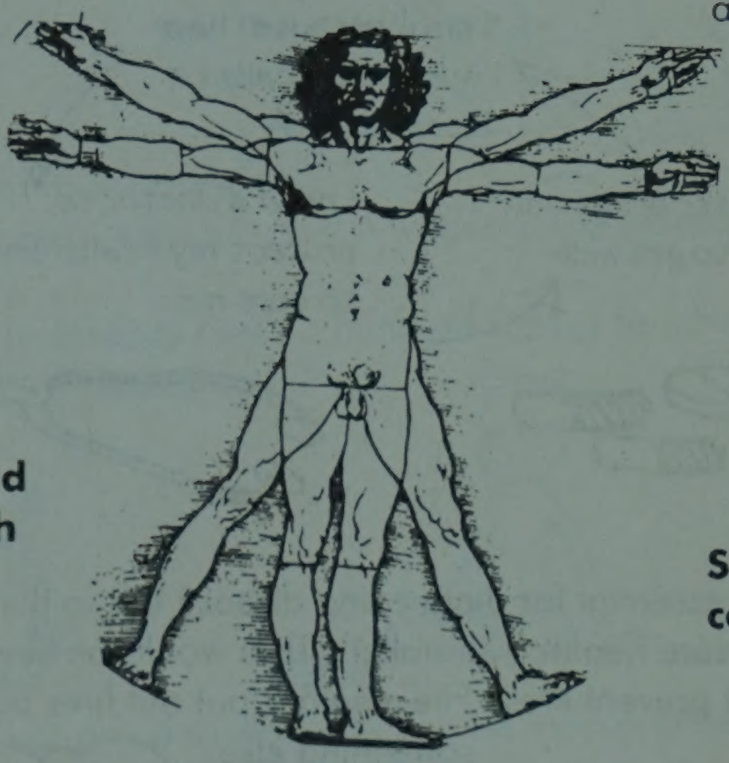
Thailand has 1 doctor per 5000 population. Malaysia has 1 per 3000 population. In contrast India has 1 doctor per 2400 population. Thailand has an infant mortality of 27/1000 and malaysia of 15 as against India's figure of 79 (1993 figures) The health status of many nations with far less doctors is far better than ours.

What then Determines Health?

Nutrition

A Livelihood that satisfies (when labour is one's prime want)

Healthy Living conditions (especially drinking water and sanitation)

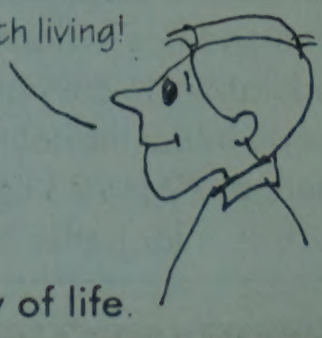


Access to a good quality of health services

Safe working conditions

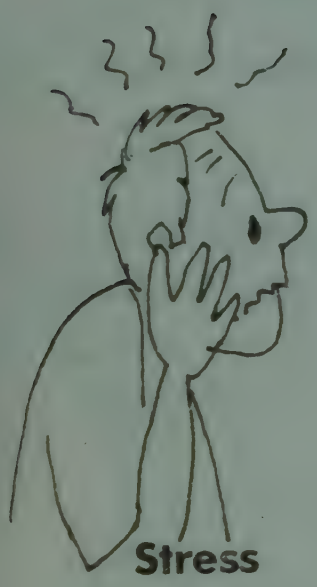
A Healthy Environment

Ah! All this would make life worth living!



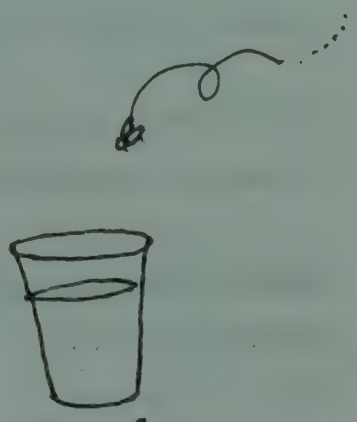
Health is a reflection and measure of the quality of life.

What are the causes of ill health?

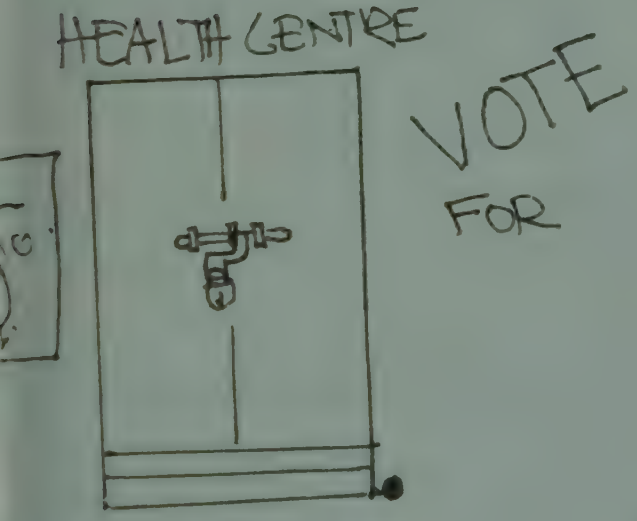


Stress

Malnutrition

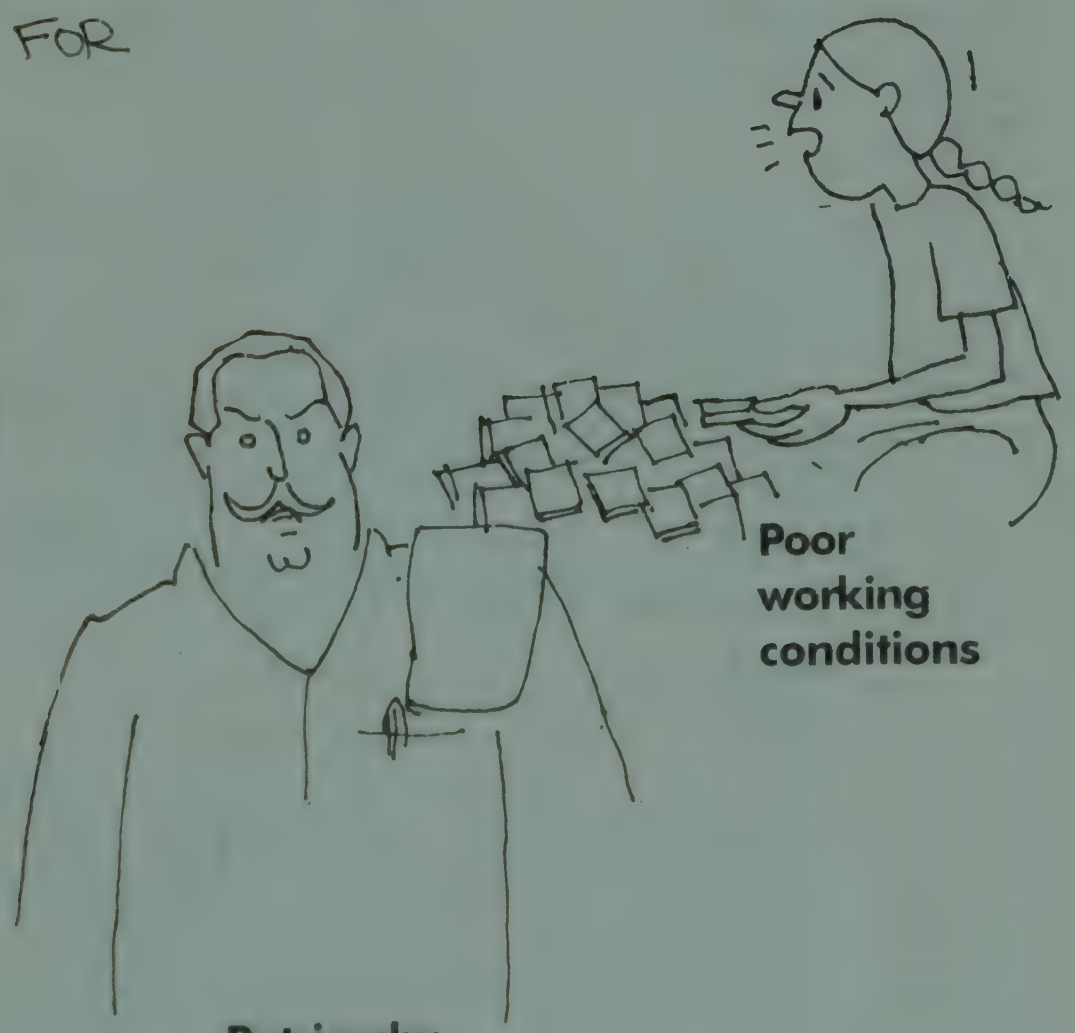


Unsafe drinking water and poor sanitation



Lack of access to or poor quality of health services

Poor living conditions



Poor working conditions

Patriarchy

Malnutrition

Poor nutrition is the most important cause of ill-health

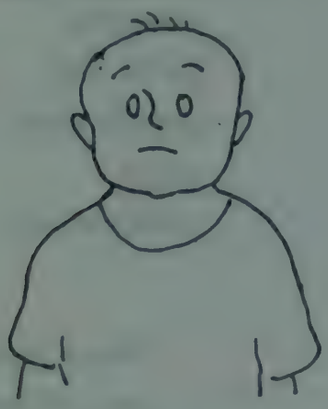
But we don't have people dying of starvation!

True. that happens only in a famine - or in a hunger strike!

Most malnourished die due to ordinary infections.

Diarrhoea, acute respiratory infection, measles, tuberculosis, malaria - are the usual causes of death in the malnourished.

Malnourished people are more susceptible to diseases as their body's resistance is less. They become sick sooner.They remain sick longer. They recover less.



This child has diarrhoea but that is nothing serious.

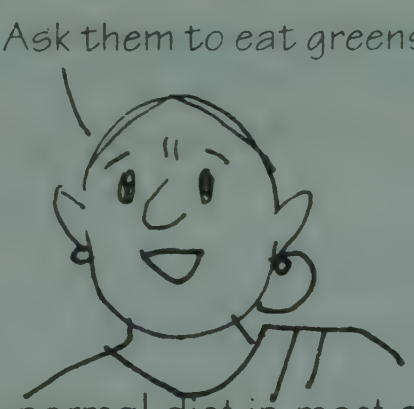
This child too has diarrhoea but it is life threatening.

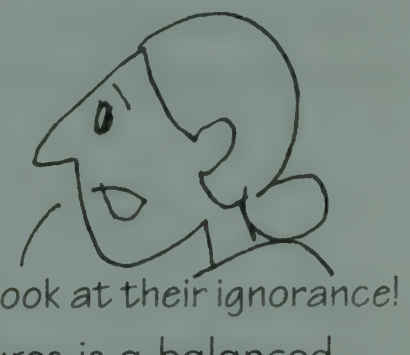
Malnutrition can lead to frequent infections.

Frequent infections can lead to malnuturition

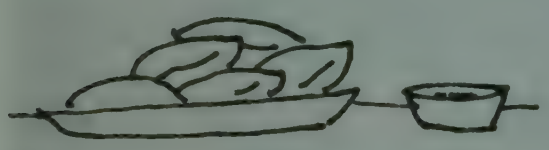
The doctor is less likely to get TB from his patients. but his fellow worker or family members will get it easily.

It is estimated that in India over 2 million deaths per year are related to malnuturition. But in all of them the immediate cause of death is an infection.



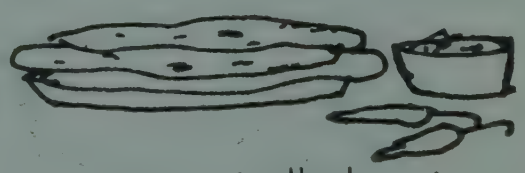


People are not ignorant. The normal diet in most cultures is a balanced one. They need not be `educated ' on it.



idly, sambar, chutny and oil

Whether it is



or roti, dhal, onion and chillies

Both have all that one needs.

THE MAJOR CAUSE OF MALNUTRITION IS HUNGER!

Lack of knowledge is not the problem.

THE MAJOR CAUSE OF HUNGER IS POVERTY.

Lack of food availability is not the problem.

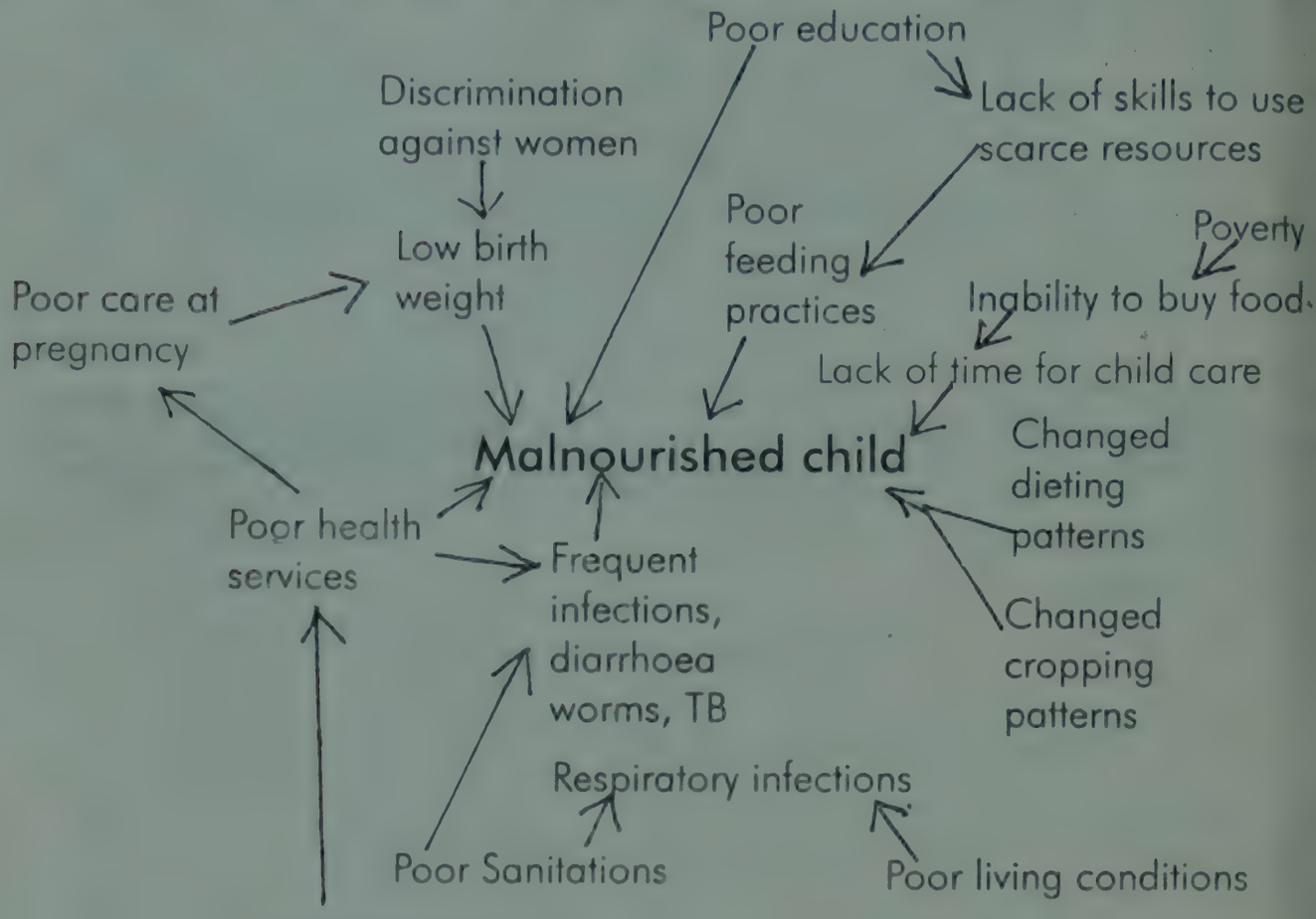
30 to 40% of people live below the ***poverty line***.

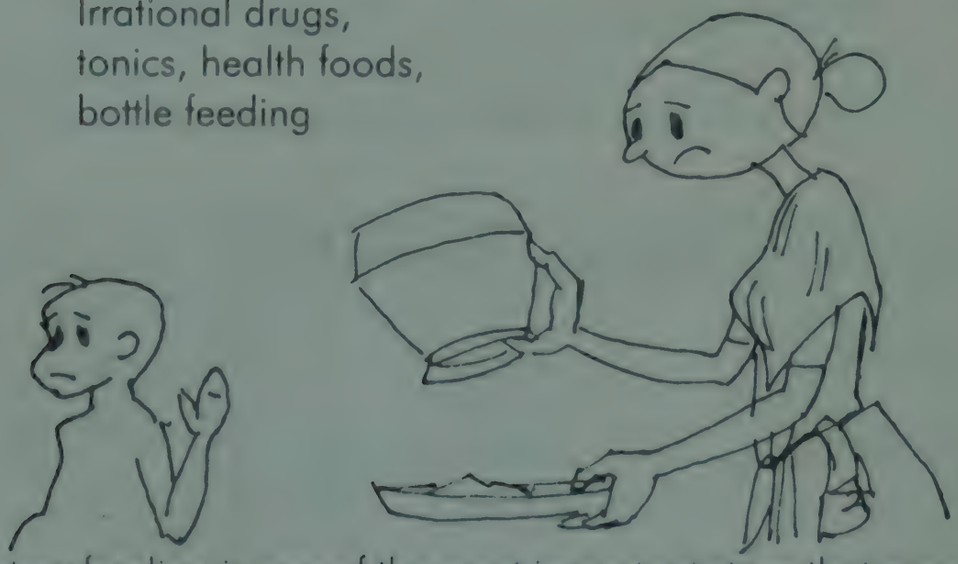
What is that ?

It means they do not have income sufficient to buy the minimum amount of food needed. It means they go to bed hungry.

Three hundred to four hundred million people in India go to bed hungry.

Inability to buy food is not the only way poverty leads to malnutrition. For it's level of income India's malnuturition is much more than can be expected. Countries with far less income have much less malnutrition





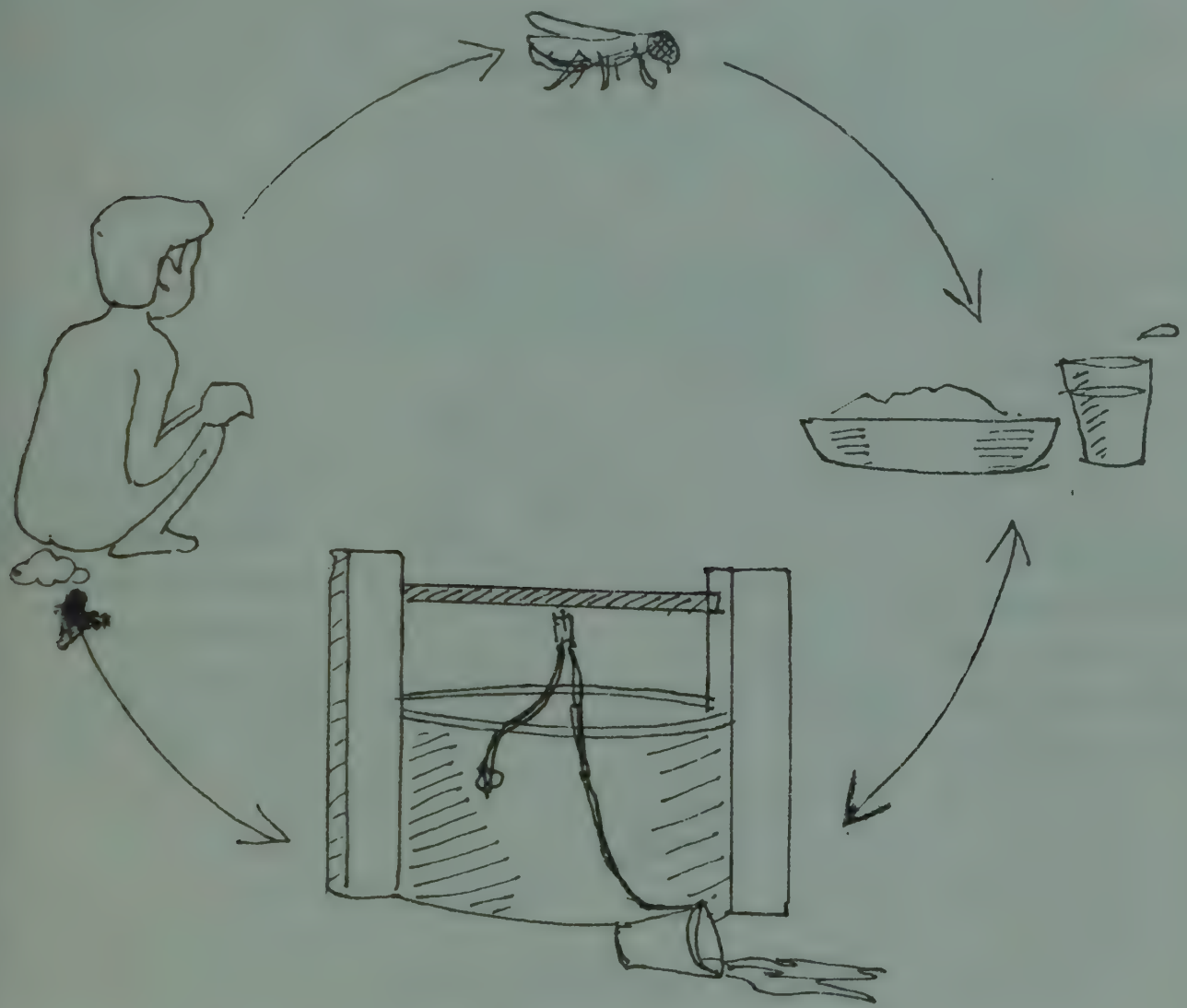
Supplementary feeding is one of the most important steps that a government can take to tackle child malnutrition. But by itself it is not adequate. People are often surprised at why supplementary feeding is not more effective. Do you know very often poor mothers lessen a corresponding amount of food at home? So supplementary feeding becomes a substitute feeding.

Health education can make a substantial difference. (Mothers are prepared to buy costly health foods & medicines because they care for the child.) But this health education seldom happens. Why?

The most affected by malnutrition are children especially girl children. It leads to stunted growth and weak mothers in this generation and low birth weights in the next generation too!

Safe drinking water & sanitation

Most infectious diseases spread through water.
Water gets infected due to poor sanitation.



The diseases that are spread this way are
Diarrhoea
Cholera
Dysentary
Jaundice(Hepatitis)
Polio
Typhoid
Intestinal Worms

Mosquitoes and the flies breed in stagnant pools of water and in a dirty environment.

Mosquitoes spread malaria, filaria, dengue and encephalitis (brain-fever)

Provision of safe water can be done today!

The tragedy of water borne infection is that almost all of it can be prevented by providing safe water and ensuring sanitation.

He inspects the water tank regularly. Ensures it is chlorinated daily.

Ensures the water supply pipes are not leaking and drawing in sewage or dirty water.

THIS PANCHAYAT LEADER HAS ENSURED SAFE WATER.

Checks out every outbreak of diarrhoea. (Three or more cases in a week) to find out sources of infection.

He ensures the well or tube well is repaired, lined properly and no one defecates within fifty feet.

Ensures the water from pond or unsafe well taken from an infiltration gallery. He got the government to build one. Or pumped into a tank and chlorinated daily for drinking.

THIS PANCHAYAT CHIEF HAS NOT.

Total sanitation can be ensured today.

Built soak pits for homes not connected to drains.

Got government funds to build drains. Started a fine for those who do not keep the drain unblocked in front of the house.

THIS PANCHAYAT CHIEF HAS ENSURED TOTAL SANITATION.

She got all households to acquire latrines arranged loans for those who needed it. Local masons were trained to build it.

Organised a clean the village campaign and organised youth camps to check that no stagnant water remains.

Arranged that each family pay Rs 5 monthly towards maintenance before he got this built.

Got government funds for public latrines for the poorest.

THIS PANCHAYAT CHIEF HAS NOT!

Ask my husband. I can't do anything.

Poor living conditions are a major cause of ill health.

Overcrowded homes!
Damp, leaky, poorly built houses.
Smoky environs.
All lead to increased TB and respiratory infections.

Ecological changes too affect health:

Migration within rural areas and to urban areas and squatter settlements are major sites of diseases.

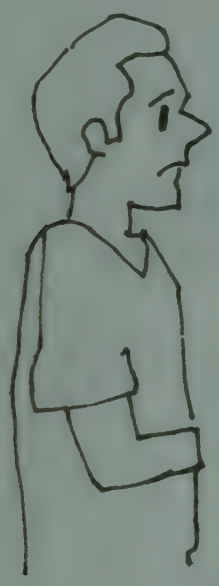
Waterlogging due to canals spreads malaria.

Water standing in paddy fields with poor drainage promotes mosquitoes that spread brain fever

Poor working conditions are a major cause of disease.

Kannamma works 18 hours a day. Exhaustion makes her body prey to all sorts of disease.

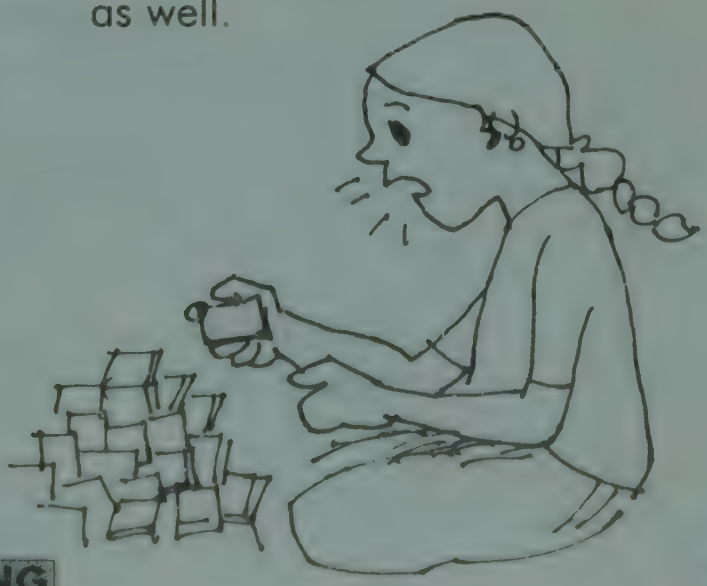
Kandan has been exposed to dust in his workplace for over 15 years. He now suffers from severe breathlessness and will eventually die of it.



This labourer's limb was cut off by the threshing machine. The machine does not have the protective cover that is mandatory for safe use.

This girl has been packing match boxes in an ill-lit, crowded room for over 7 years. She has chronic backache and headache and may be affected by TB as well.

This man has weakness of both lower limbs and a burning sensation all over the body. He sprays pesticides once or twice a month.



Health is a basic human right

"Health is a state of complete physical, mental and social wellbeing and not rnerely the absence of disease or disability"-

.... Alma Ata Declaration, 1978

THERE WAS A DREAM : (Long back, just before the medical profession was founded in the heyday of the French Revolution: 1790!)

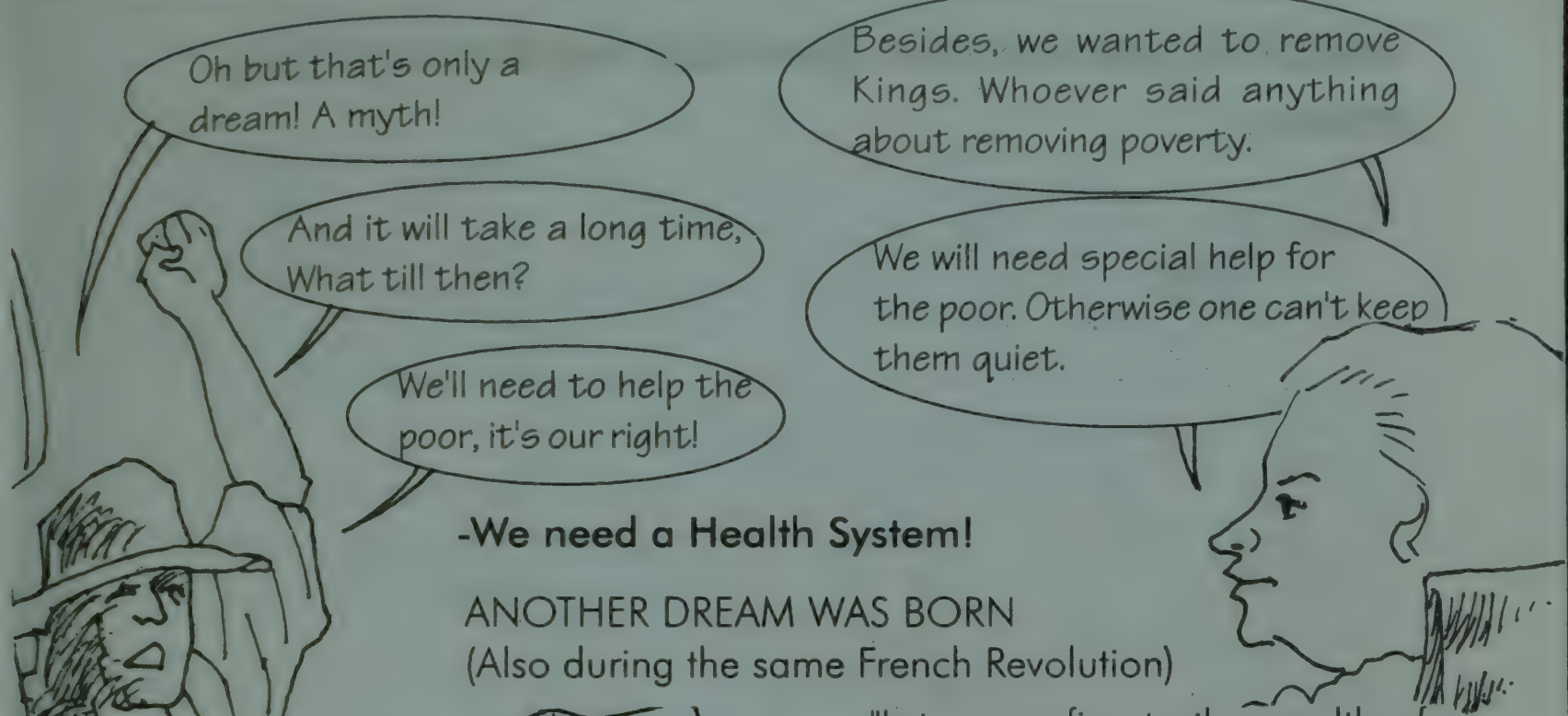
*Slogan of the radical `Mountains.' All hospitals and faculties of medicine were actually dissolved in 1791

A dream of the total disappearance of diseases in an uncontrolled, dispassionate society restored to its original state of health

"Gradually, in the young city, entirely dedicated to the happiness of possessing health, the face of the doctor would fade, leaving a faint trace in men's memories of a time of Kings and wealth in which they were impoverished sick slaves"

`At last, medicine will be, what it must, be knowledge of natural and social man.'

Lanthenas, Girondist, De l ' influence de liberte sur la sante' Paris 1792.



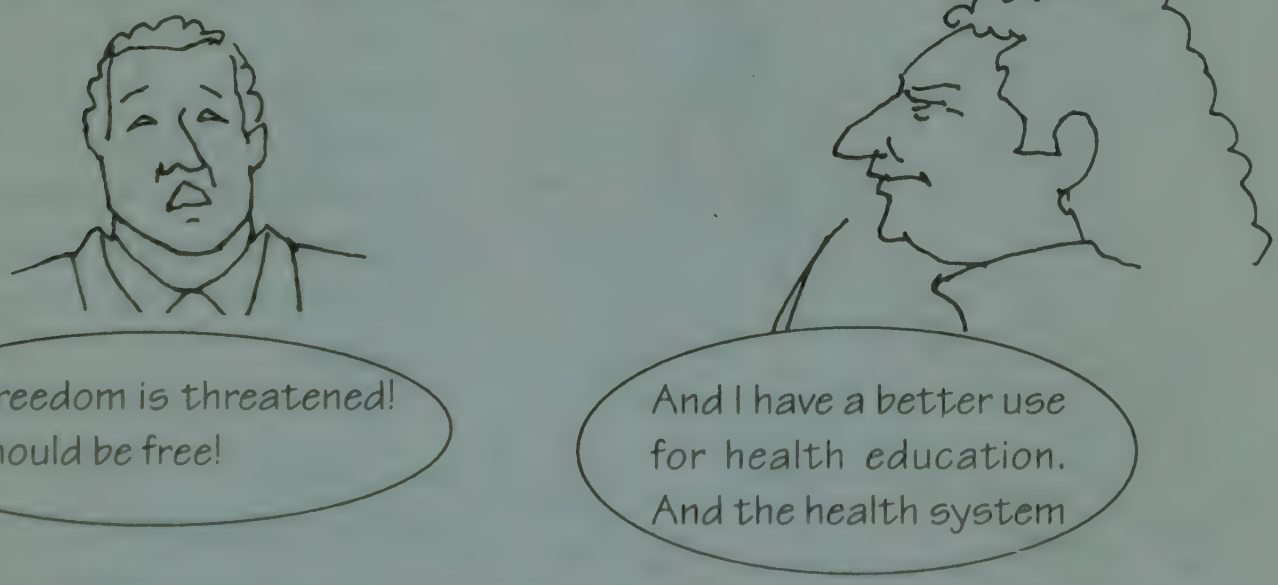
-We need a Health System!

ANOTHER DREAM WAS BORN
(Also during the same French Revolution)

"Let us confiscate the wealth of Church and use it to pay priests and doctors- one to save the souls, another to save the bodies" - Sabnot de l' Avessiere, Paris 1789.

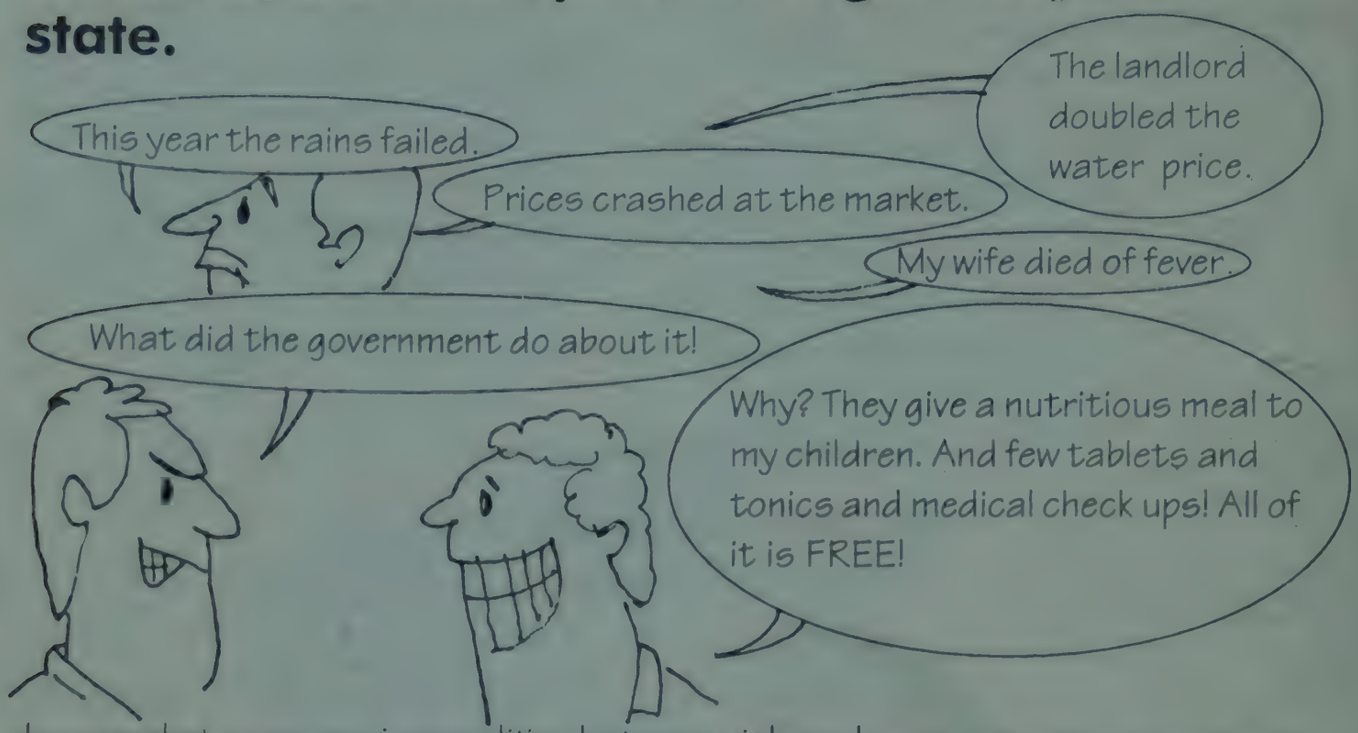
"The doctor would no longer have to demand a fee from his patient; the treatment of the sick would be free and obligatory - a service that the nation would provide as one of its sacred tasks; the doctor would be no more than the instrument of that service."

But the doctors didn't agree and the rich had other aims!

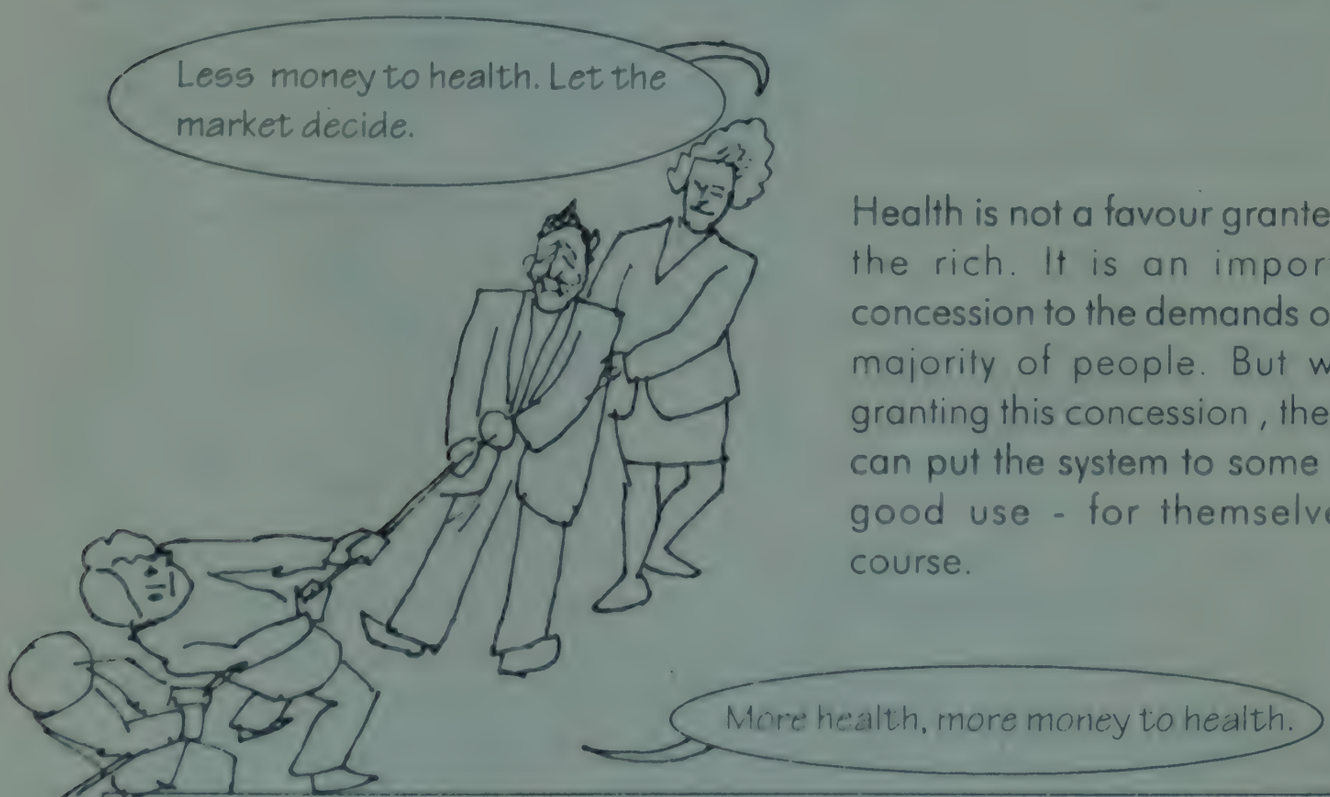


In 1917, after the October Revolution, this dream was realized to a large extent. Other socialist countries followed this model.
Most newly formed socialist states set up a nationwide health care systems which were to provide a high quality of health care accessible to the entire population. Health was for them a fundamental right. ut in market economies health played a different role. Reed on.

Health system can provide legitimacy to a state.



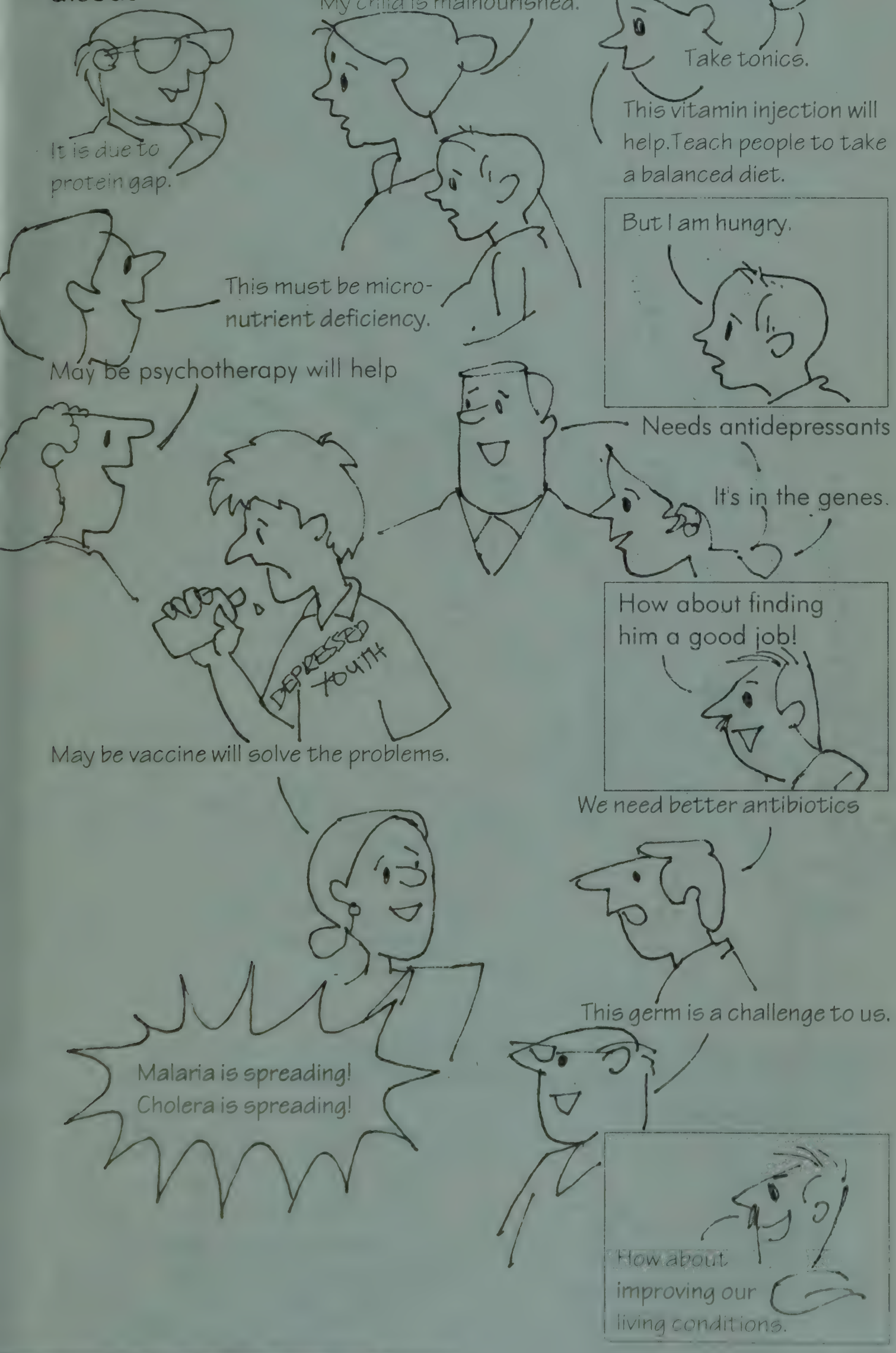
In a market economy inequalities between rich and poor are seen as necessary and desirable. This of course favours the rich. But the state to have legitimacy, i.e. to appear as an impartial state which is fair to rich and poor alike - must seem to be doing something to help the poor. Health is an important institution for such legitimacy.



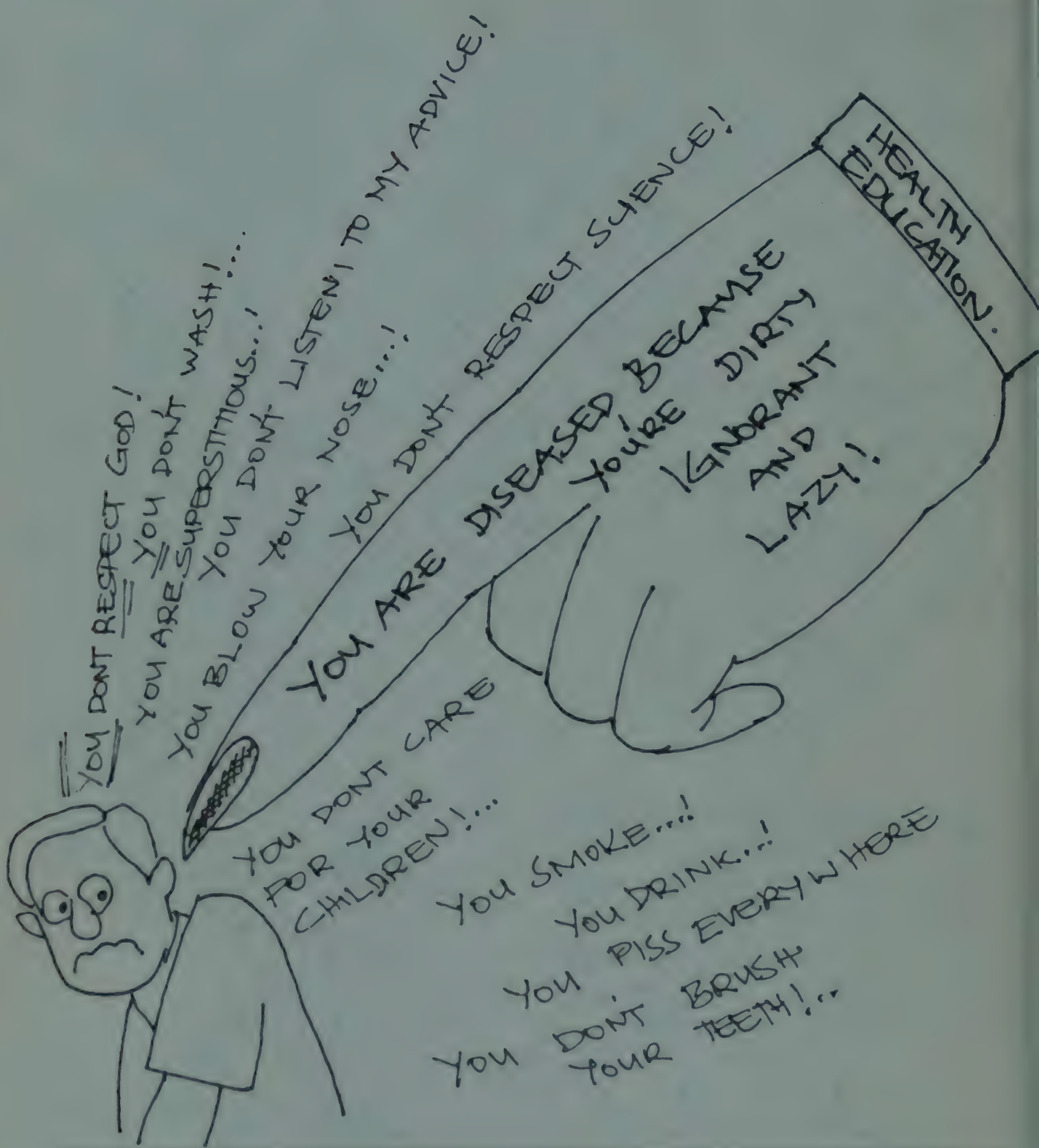
Health is not a favour granted by the rich. It is an important concession to the demands of the majority of people. But while granting this concession , the rich can put the system to some very good use - for themselvesof course.

In almost all European market economies over 80% of all expenditure in health is by the state. In countries like United Kingdom and Sweden most of the health care is through a National Health Service. While in other market economies the providers of health care are private, but it is paid for by public funds. Compare this to India where 78% of health expenditure is private.

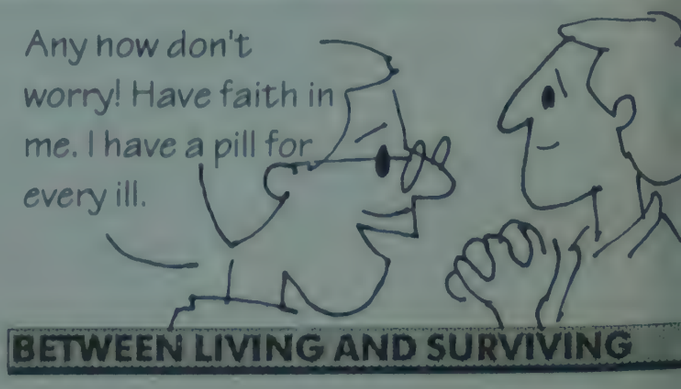
The Health system can obscure the social factors behind disease.



"IT CONVERTS THE VICTIM INTO THE ACCUSED"



In Indian culture diseases are often seen as punishment for one's sin. This adds on conveniently.



But even better, it converts purely social problems into medical ones.

The Indian population programme's greatest achievement: Provide a popular answer to India's poverty.

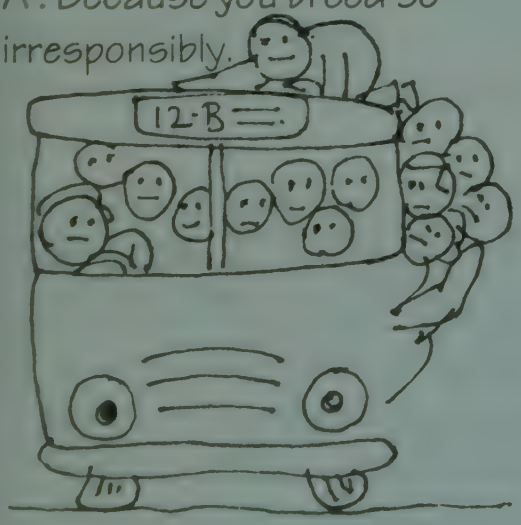
What is the cause of our poverty?
of our unemployment?
of our backwardness?

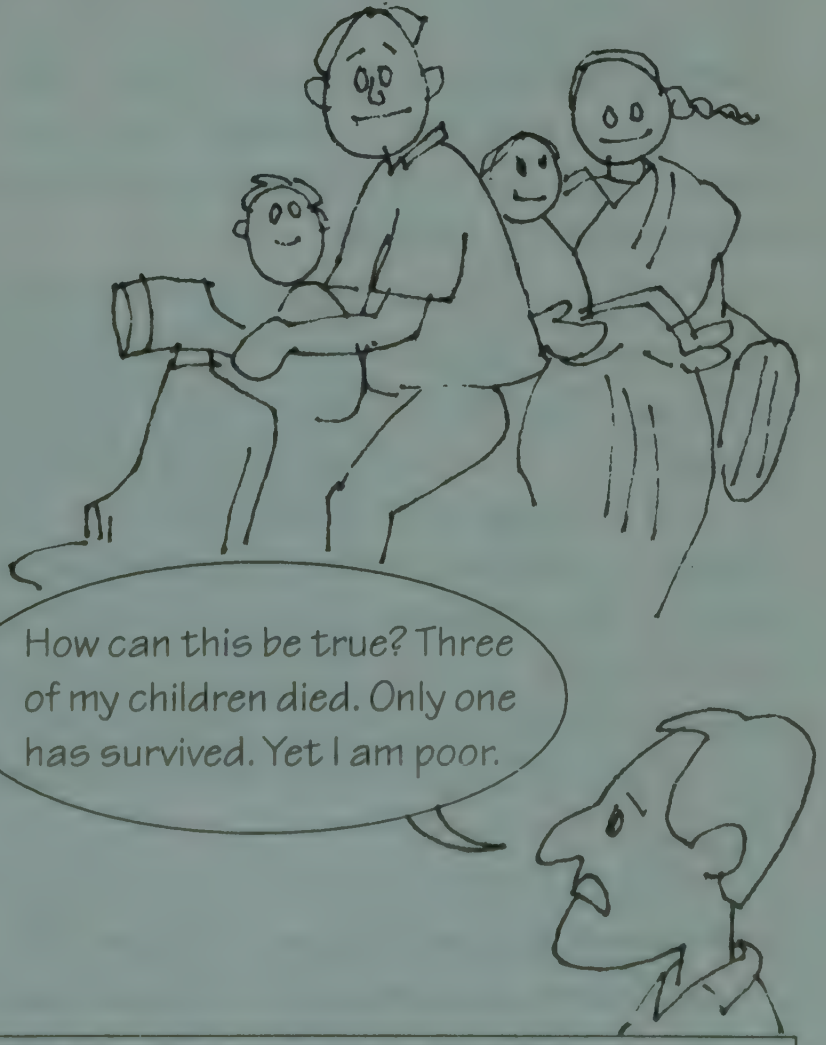
POPULATION EXPLOSION

THE GREAT HEALTH MESSAGE

Q : Why are you poor?

A : Because you breed so irresponsibly.





There are countries with higher population density and less poverty (e.g. Japan) and those with less population density and more poverty e.g. sub-Saharan Africa !

Then why does population increase?

A) Poverty causes population increase.

"Development is the best contraceptive"

To a poor family children are their only savings, their investment for the future in old age or if disability strikes. It does not cost much to rear a child in a poor household. And the child starts earning soon.

Eradicate poverty to control population.

Most developed countries have a problem - inadequate population growth!

B) Patriarchy causes population increase!

World over studies have shown that women `desire' to have only two or three children. But seldom is the choice theirs. Men make the decision. And the desire for a male child is at the root of many large families. Whenever gender equality situation is better and women's education is more the family size comes down by itself.

C) High infant mortality causes large families!

To guarantee a surviving male child, one needs to have many children. The fear of children dying means the necessity to bear more. Help the mother to safeguard the child, to escape the agony, the helplessness and the guilt when faced with each child's death and mothers will limit their families.

D) Lack of access to family planning services and information.

Despite the fact that over 3000 crores of rupees (half the health budget) goes to family planning in many villages women still have no information about condoms or pills. Nor is it easy to get them in a village. Sterilization services are available but only in centres discredited by their inability to provide any another medical services.

In controlling population, the programme's success has been limited.

But in shifting the blame for poverty (in popular perception) from the rich to the poor the programme has been a great success.

In 1941 birth rate was 45 per 1000, falling to 41 per 1000 in 1970 to 33 per 1000 in 1980 & 30 per 1000 in 1990. In that last decade though over 3000 crores was spent on the family planning programme (about half the entire health budget) the fall in birth rate was negligible. The country was to have reached a birth rate of 25 per 1000 by 1984!

What are the real causes of poverty?

***Inequality in ownership of land, capital and other resources.**

*** Power exercised by the few. Power by which the rich came to acquire resources and power by which they can retain it. This power is exercised though a number of institutions the most important of these being the state.**

Health care system as Safety Net

Since 1990s, under pressure from the World Bank, India has been undergoing a major economic reform called `structural adjustments.' One major outcome of this reform will be a greater emphasis on **health care as a safety net** - so that the increasing poverty caused by the reforms does not become visible in the form of increased death and diseases. The reform also aims to limit Govt.. expenditure on health and develop the role of the private sector. But there are differences between health as a fundamental right as understood by the international conference at Alma Ata and World Bank's concept of health care as a safety net

Health care as a fundamental human right Alma Ata Declaration. 1978.	Health care as Safety Net: World Bank Report 1993.
1. Comprehensive Primary Health care 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services.'	1. Selective primary health care: Tackles only six areas identified at national centre as important.'
2. National Health system bringing health care as close to the people as possible.	2. Most curative services to be provided by private sector.
3. Emphasis on process: Intersectoral linkages, equality, basic needs & people's participation.	3. Emphasis on elimination of disease by targeted technological means. Technological efficiency measured in terms of number of deaths averted for unit cost:
4.People have right and duty to participate individually and collectively in planning and implementation of healthcare.	4. State shall decide which diseases can be tackled at least cost and focus only on these (so that it can keep its expenses limited).

The Alma Ata declaration titled `Health for all by 2000 AD' was signed by most countries of the world. It is essentially a recognition of health as a basic human right and promise to provide ' primary health care' to every single individual by 2000 AD. Based on this declaration in 1984, India framed its current National Health Policy. Unfortunately both these documents, especially the latter have not even been read by most policy makers. Instead, in practice, a concept called selective primary health care, introduced by the Rockfeller foundation in 1983, & later promoted by World Bank but which uses much of the phraseology of the Alma Ata declaration became dominant. At the WB suggestion concepts were restructured such that immunization became its focus. The health - as - safety net concept is an extension of this.
Lets look closer to understand how `health - as - safety - net' works!

Ensuring survival

(AS AGAINST ENSURING A GOOD QUALITY OF LIFE)
The logic of the Safety-net-concept explained:-
(Based on quotes from World Development Report (WDR) 1990 and 1993, published by the World Bank)

"The short run effects of adjustment, however can create difficulties for two reasons. First the process of economic restructuring is often sluggish and uneven. Firms and labour markets take time to adjust, and in the meantime economics can suffer higher unemployment or underemployment and labour incomes may decline. Second, demand reducing measures may be unavoidable, and these are likely to hurt the consumption of the poor and non-poor alike...." - pg.103. WDR, 1990.

"Two broad groups in need of special attention : those unable to participate in the growth process and those who may temporarily be in danger when events take on unfavourable turn. The first group needs a system of transfers that will ensure them an adequate standard of living The second group is best served by a variety of safety nets..." - pg. 101, WDR 1990.

"Most of the poor in the developing world live in rural areas, and it is there that the need for effective transfer and safety nets is greatest....." Pg. 102; WDR, 1990.

"....In most societies providing health and education for the poor commands a degree of political assent that is altogether lacking for transfers of income or of assets such as land. Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences, as World Development Report 1990 emphasized....." Pg. 55, WDR, 1993.

"Too often, government policy has concentrated on providing as much health care as possible to as many people as possible, with too little attention to other issues. If governments are to finance a package of public measures and clinical services, there must be a way to choose which service belong in the package and which will be left out. The next section describes a measure of cost-effectiveness for health intervention that helps with this choice...." Pg.57, WDR, 1993.

Fundamental right or safety net?

If too many people die then the structural reforms will be discredited and face political opposition that may review the process. Maintaining adequate capable human labour is also important and a frequently addressed concern in the World Bank Report. But as structural reform also lowers the amount of money available for public spending the challenge for World Bank is to find a set of health measures that cost less while at the same time not allowing the health status to deteriorate visibly. The challenge is to ensure survival. The quality of life is no longer the central concern.

In contrast , the Alma Ata document states:
" Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of the level of health that will permit them lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justices ....." para. V, Health for All by 2000 AD., Alma Ata declaration.

For the Alma Ata declaration : The question is not the least cost approach to ensure survival. It is the best possible way to ensure adequate quality of life.

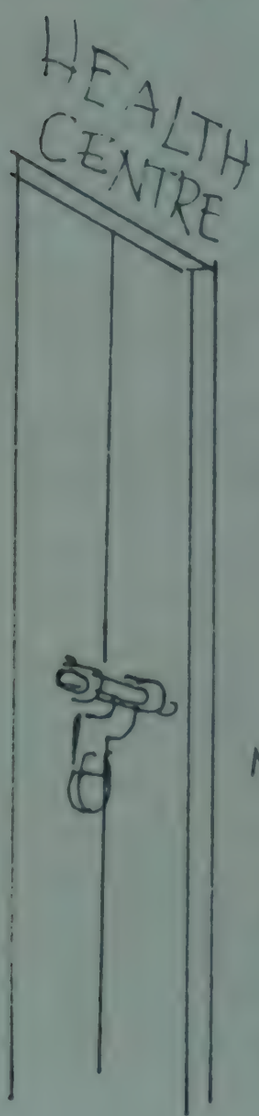
Substituting safety nets for fundamental rights - The Indian way

The Bhore committee report and in most ways the National Health Policy document of 1982 articulate the same spirit as the Alma Ata declaration. Unfortunately most executives of health policy have not read this report. The few who have dismiss it as impractical. Instead over a number of foreign trips and negotiations with World Banks and donor agencies for getting funds, the policy is tuned to that spelt out in the WDR reports. By providing a small fund package usually less than 5 percent of the total funds - the donor agencies can substantially alter (by conditionalities) the exact health policies followed in our country.

In this they are helped by the fact that the health policy as implemented in India has always had the role - of legitimization and as a concession to public demand. In addition Indian government's Health expenditure and health policy has always been a major promoter of a private health sector. The WDR report and Safety net concept is only a carry forward and enlarging of this approach!
Let us see how this government's health structure works.

The government health care delivery system

Sub-Centres	One for every 5000 Population	Has two health workers - one male and one female
Primary Health Centres	One for every 30,000 population (20,000 in a tribal area)	Has two medical officers, a nurse, pharmacist, lab assistant and others.
Taluk Hospitals & Community Health centres.	One per 1 lakh population	Has a team of specialists.
District Hospital	One per district	Should have all facilities a good referral hospital needs.



BUT THERE ARE STILL LARGE GAPS:

Many villages are not covered by such sub centres.

↓

Many sub centres and PHCs exist only on paper. They have no building and no staff.

↓

Many PHCs or sub-centres have no staff posted or posted but on leave.

↓

Many PHCs have staff present but no drugs or other medical supplies.

↓

About 1/3rd of all PHCs will have one or other of the above problems.

↓

BUT THAT IS NOT "THE BIG PROBLEM"!

The big problem : even when all of it is available - nothing much happens!

Case - study 1

.....is a village in Haryana. It has a primary health centre with a good building, good accommodation for staff and excellent facilities including 4 hospital beds and a laboratory. The doctor comes to the PHC by 9 am and by 11 am he leaves. He sees an OPD of over 50 patients in this time, quickly disposing them with some tablets each or advising them to go to the district hospitals. About three or four days a week he does not come at all and one or other staff - the nurse or pharmacist `dispose the cases'. The female MPWs in the sub-centres concentrate on fulfilling of family planning quota - somehow finding some women who are ready to get sterilized. She registers all pregnant women, but little ante-natal care of any sort gets done. She fulfils her immunization target though an independent survey shows that over 50 percent children are un immunized. But nothing else happens!

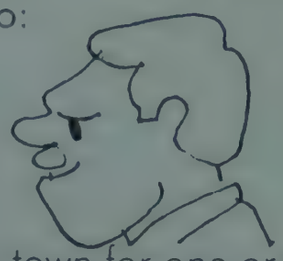
Case-study 2

In Tamilnadu, public administration, especially in health is very good. Thus all the staff of the PHC and sub-centres here come every day for at least 3 hours in the morning. Family planning targets are met easily and all children are immunized. All pregnant women are registered and almost all get their TT injection. Many of them are given iron tablets but few women eat them. No other ante-natal care or child care or care for women occurs. Every month a few blood smears are taken, sputum of a few patients are examined, and a few ORS packets are distributed. This is what passes for malaria, TB and diarrhoea control programmes. There is a paid nutrition worker who weighs children once in a while and distributes a ball of nutrition mix to children, less than 5 years old. The mother hard pressed to feed so many mouths, decreases a corresponding amount from what she would have otherwise given the child. If you go to the villages you would see that good administration has meant a tremendous improvement in the 18 registers or so that the nurses have to maintain. But its impact on public health has been much more limited (except for immunization preventable diseases). Malnutrition, disease & even deaths remain much the same.

When health care is what a benevolent state pours (or even forces) on to a passive people, it is unlikely to succeed!

What do people do for their health needs?

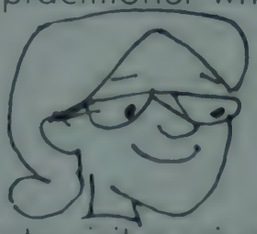
It is estimated that in most states only about 15 out of every 100 actually go to a government centre. All the rest go to:



A) The `R.M.P. - or quack.
Usually worked as a doctor's assistant in town for one or two years and now set up on his own!

B) The midwife:
Especially for pregnancy related problems and at delivery but for a number of other women's health problems also.

C) The HAKIM or VAIDYA
The local indigenous practitioner who leant this trade from the elder of his family.



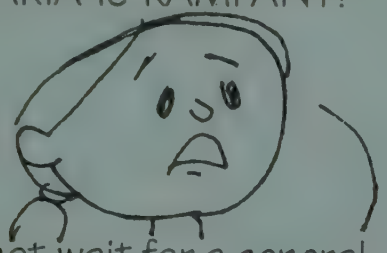
D) To the nearest town to visit a private MBBS doctor, or qualified ayurvedic practitioner or a homeopath.
In case of serious illness, especially if one requires hospitalization the poor will go to a taluk or district hospital, and the better off will go to a private nursing home. About 75% of persons are hospitalized in the government sector only.

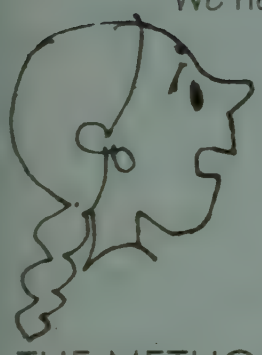
In India out of every Rs.100 spent on health, Rs.78 is spent in the private sector. Only 22 percent is Govt.. expenditure. In the USA out of every Rs.100 spent on health, Rs.56 is in the private sector and Rs.44 is in the Govt., sector.
In most European countries out of every Rs.100 spent on health Rs.80 is spent by the Govt., In countries like UK, Sweden, Japan it can be as high as Rs.95 out of every Rs.100.

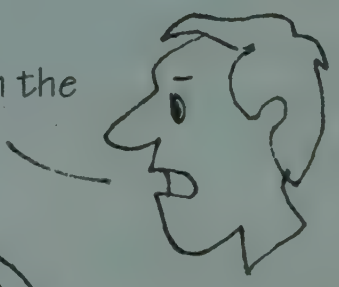
But what about disease prevention?

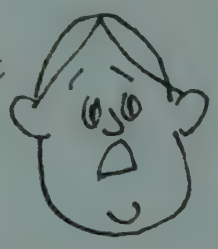
THE SITUATION : (in 1947) MALARIA IS RAMPANT!
Over 70 million cases.

THE PHILOSOPHY









THE METHOD:

THE RESULTS:
Malaria falls dramatically: From 70 million cases in 1947 to less than 60,000 in 1967. Deaths drop from 2 million to zero.
But now it has risen to 7 million cases per year and is rising. Death due to malaria are in thousands now and are rising! Worse! , a strain of malaria more resistant to drugs and more harmful is spreading.

Programme with a difference:
The eradication of smallpox is one of the most significant medical achevements of the twentieth century. Vaccination helped, but what was crucial was a better understanding of the diseases that helped to isolate sick people and prevent disease in its contact. As well as a massive political and financial will to do it across the globe.
Guinea worm eradication is the other successful programme.
Unfortunately most diseases do not have those features of these two diseases that made their eradication possible.

The fate of wars.

Programme	Year of initiation	Present status
National Leprosy Control Programme	1954	Prevalence rate exceeds 10 per 1000 in 76 districts. Hope of control is there but likely to be elusive.
National Sexually Transmitted disease programme (combined With AIDS control in 1987).	1954	High prevalence rates suspected. Little details known. Likely to be rising.
National Filaria control programme.	1955	Population at risk increases from 25 million in 1953 to 136 million in 1986 and 304 million in 1981. Cases with chronic lesions continuously rising from 5.4 million cases in 1960 to 19 million in 1989.
National Cholera Control programme (Reclassified in 1981 as National Diarrhoeal diseases control Programme).	1955	Cholera fell from 1.76 lakh cases with 87,000 deaths in 1950 to only 5808 cases in 1985 and 155 deaths. Since 1992 cholera is back and increasing. Deaths due to other gastroenteritis has however remained steady or increased. (Cholera is one type of gastroenteritis.)
National Kalazar control programme	1956	Cases almost disappeared by 1960s but back in a major way in North Bihar and Bengal (estimated 25,000 cases with 2,500 deaths in 1990)
Plague	1956	Disappeared by fifties. Outbreak in Surat in1995.

And now new enemies are rising!

Jaundice on the rise. Hepatitis B is a major public health threat.

AIDS

AND NOW NEW DISEASES ARE BREAKING OUT.

Dengue haemorrhagic fever claims over 100 lives in Delhi in 1995.

Kyasnoor forest disease: Outbreak in Karnataka.

Japanese encephalitis: First epidemics occurred in seventies. Now it is endemic.

Leptospirosis: Increasingly seen as a threat. possibly waterborne.

One cannot sustain wars indefinitely.
It has to be part of a different type of process.

It is a choice between two processes

(These categories are not mutually exclusive. The question is the way priorities get perceived.)

1. We will decide at Delhi (w
world Bank help of course
what is National Priority?

2. We will choose only those diseases that cost less money for an impact.
(*Because money is scarce*).

3. We will choose only those diseases that appear to have a clear cut technological solution.

(*Let's try vaccine for hepatitis prevention. Sanitation & health education is not reliable!!*)

4. We will choose only those disease that rely on a technological method:-
preferably a single package that can be applied uniformly.

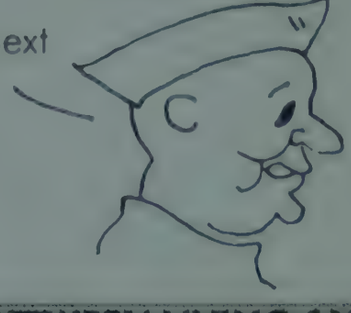
Spray DDT for mosquitoes!

5. And need no or little community involvement and can be done by an administrative chain of command.

(*Because we know that community involvement is not possible.*)

6. And can have a dramati
propaganda value to show "
GOVT.. (or World Bank) I
ACTION." What is known a
'Visible Impact.'

"Before the next election!



6. There by start a process that brings about a sustained improvement in quality of life and a change in the way the institutions of health are organized.

5. We will raise the funds needed to fulfill this for health is THE priority.

4. We will prefer those measures that have most spin off effects and are more holistic. (Let's try sanitation for hepatitis & health education for hepatitis B. It will tackle many other diseases too.)

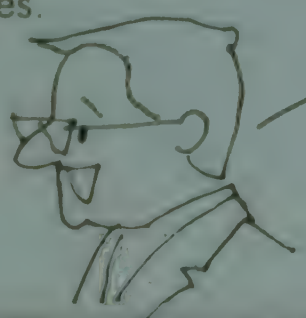
3. We will choose from diverse technological choice and to suit the disease specificity under local conditions.

(There are 8 measures we can use for mosquitoes control over here!)

2. We will involve the community in planning and implementation & prefer methods that gives greater scope for this!

Because, without it, no gains can be sustained.

1. We will decide locally at the level of a district or even a PHC/ panchayat as to what are the health priorities.



Before my next transfer!

A programme with a difference.

The District Tuberculosis Control Programme (DTCP)

This programme was `Made in India'. The programme is planned based on good epidemiological information. It is not a vertical health programme. It is decentralized. It is district based. It is integrated with the primary health care system.

The DTCP shall swim or sink with PHC.

The DTCP failed because the PHC failed. The PHC failed because of many reasons but largely because it was virtually taken over by a single programme; the family planning programme!
Now as the major national programmes run into problem and as cash becomes scare there is talk of integration with the PHC for a number of other vertical programmes - malaria, filaria, leprosy etc.

But the pre condition of integrating disease control programmes with the PHC are:
A. A functional PHC (with adequate funds)
B. Building capabilities to assess local health needs and plan for it -at the PHC level.
C. An effective disease surveillance mechanism.
D. A good national research and information back-up with easy access to its facilities and information.

What goes on in the private sector !

A REQUIEM.
There was once
a family doctor
who would come
and see us when ill.
He was the family's friend
and philosopher.
A lot of what he did
was advice and more advice.
Sometimes some bitter mixtures
made by a compounder,
a pill very rarely
even more rare
was a referral
to specialists or hospitals.
Today he is found
only in the movies.
And even there he is disappearing.

Today the major provider of curative health care is the private practitioner who sits in a clinic (often in two or three clinics) and works in a highly competitive atmosphere - having to impress his patients with injections and prescriptions so as to retain them. But even this man feels a threat - with the rise of the polyclinics and the corporate hospitals.

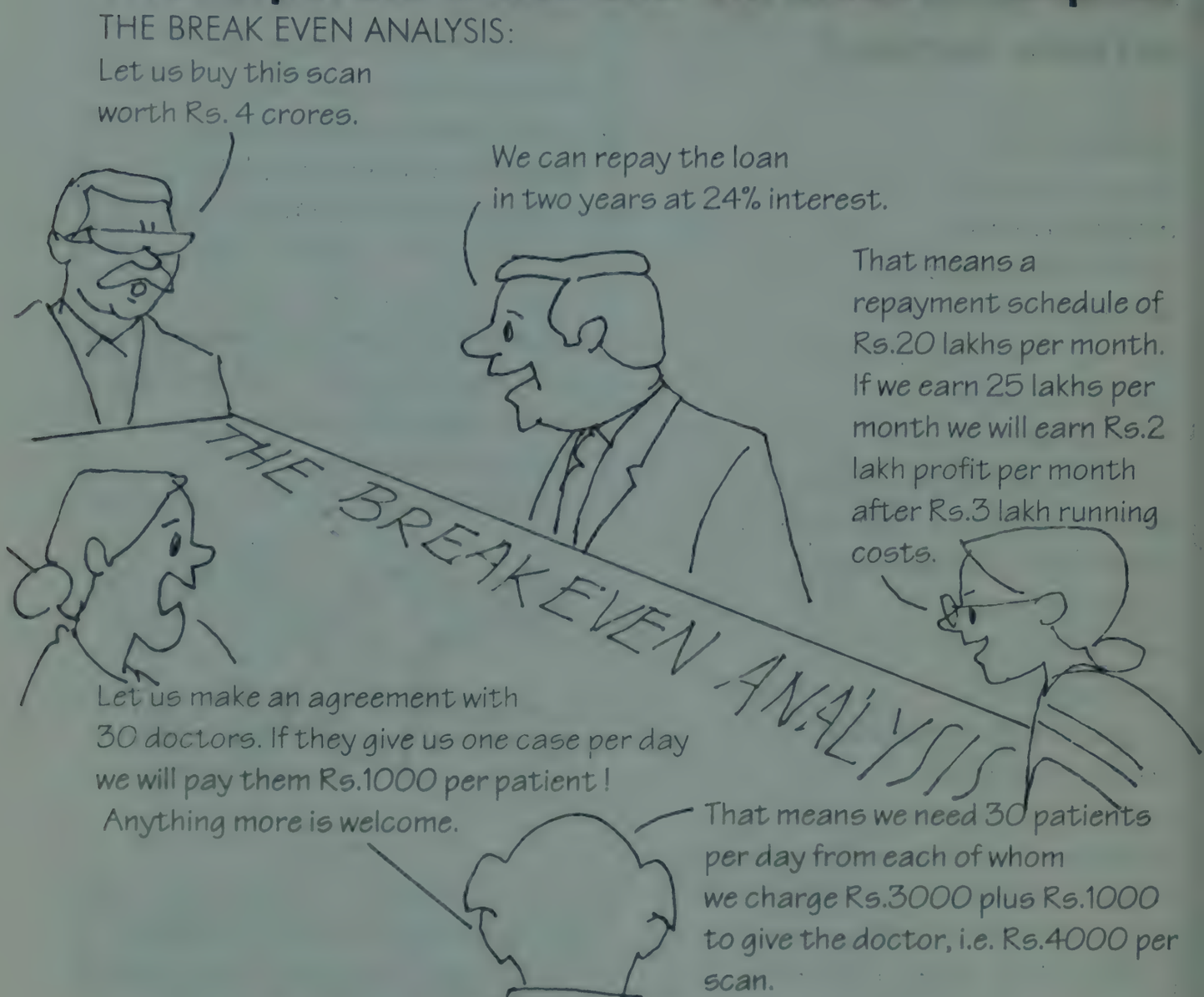
The WHO estimates that over 90% of all drugs prescribed by doctors are inessential or irrational or unscientific or downright hazardous. Why do patients consume them? Why do doctors prescribe them? Why do companies manufacture them? Why does the government allow it?

"In most circumstances, however, the primary objective of public policy should be to promote competition among providers - including between the public and private sectors. Competition should increase consumer choice and satisfaction and bring down costs by increasing efficiency.... Page 58, Investing in Health," World Bank Report, 1993.

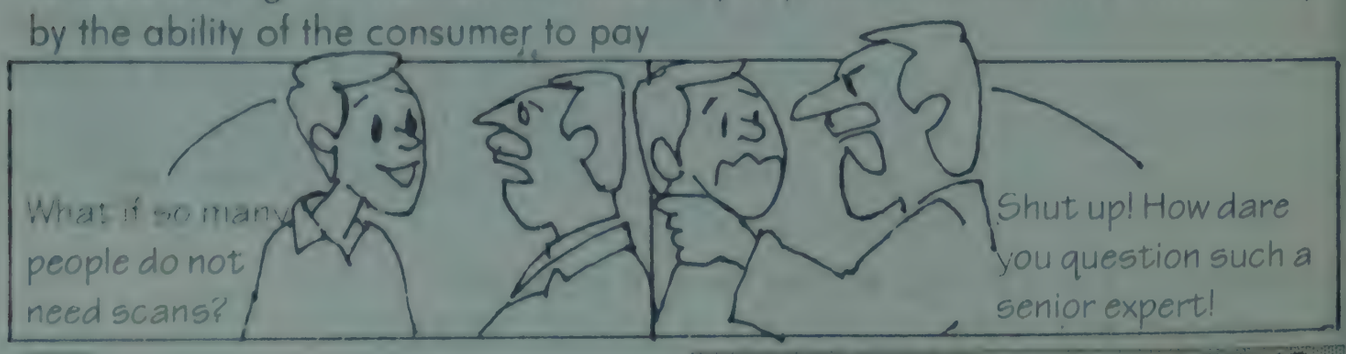
Modern industry generates its markets. It can by clever marketing, manufacture needs where none exists and it can change norms of consumer satisfaction. If industry can do this for goods that a consumer decides on and whose value he or she can evaluate it becomes much easier to do it for drugs & other medical care where a doctor decides on behalf of the consumer. In such a context competition leads to greater and greater creation of false needs and therefore higher and higher costs of health.

MARKETS ARE GOOD TO MAXIMIZE PROFITS.
MARKETS ARE NOT GOOD TO MAXIMIZE HEALTH!

The corporate sector and the modern hospital

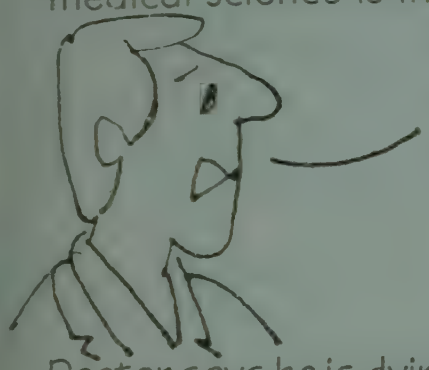


A corporate hospital is run like an industry! It is run to maximise returns on investment. The number of people who need investigation will invariably be less than that needed to break even - especially as more and more hospitals will open. Where there is a high return of investment in any sector in a market econo ny, more units of that type develop. However this will not push down costs or promote efficiency. It will rather promote more unnecessary investigations, unnecessary hospitalization, unnecessary surgeries and unnecessary referrals. Some of these are done as malpractice. But a greater trend is to shape modern medical science so that there is more and more 'need' for investigations, hospitalization and surgery. For any other commodity if there is competition the price will stabilize around its value. But since no value is too high for human life, the ability to price is limitless. It is limited only by the ability of the consumer to pay

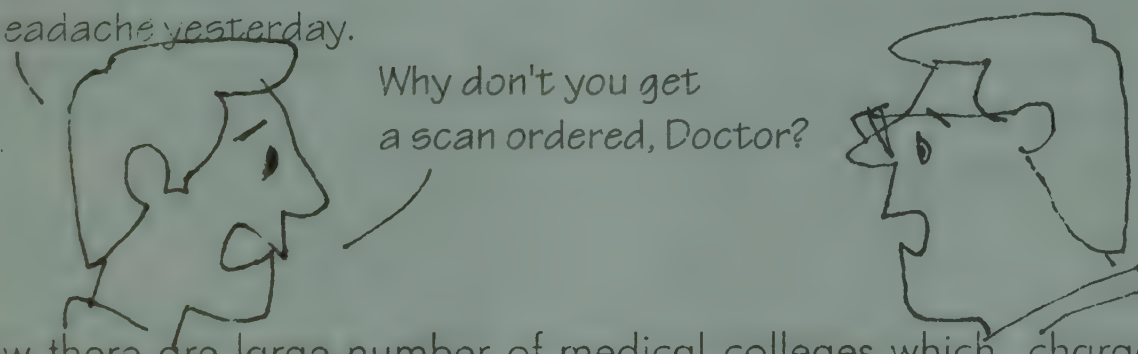


But should we get worried about corporate hospitals? After all only the rich pay?

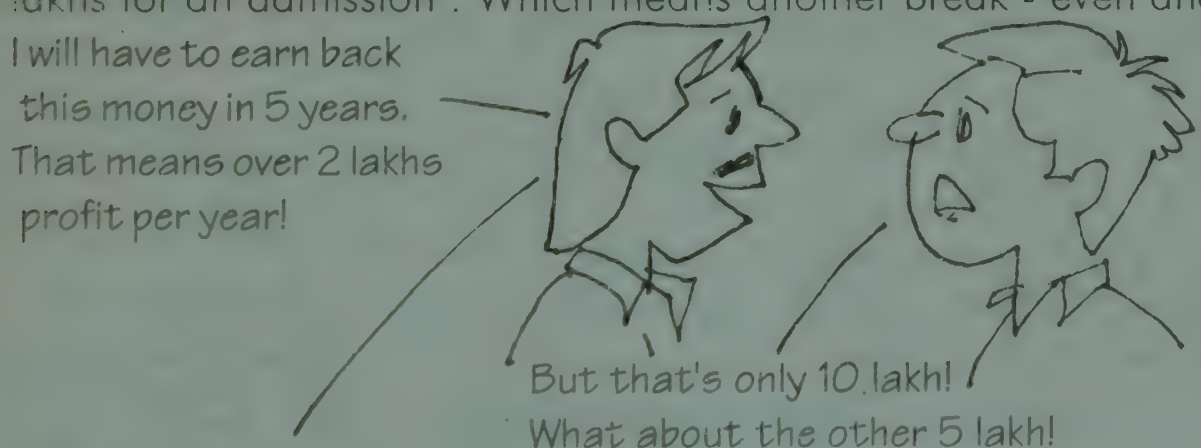
The culture of such hospitals redefines medical sciences, shoots up costs, leaves patients dissatisfied and often pauperized without improving their health. Since it is mostly senior professionals who work here, the way they redefine medical science is the single greatest threat of these hospitals.



(Tomorrow when the husband dies, the family is on the street.)

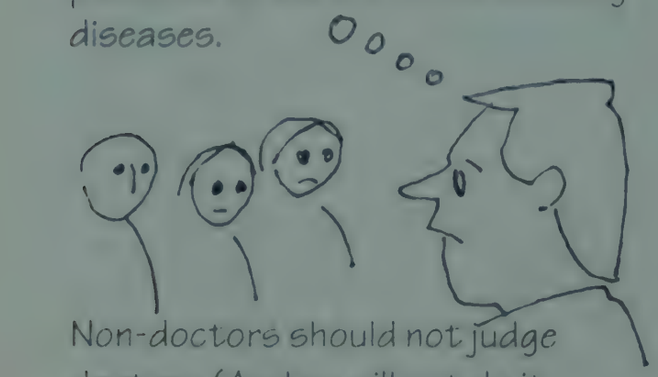


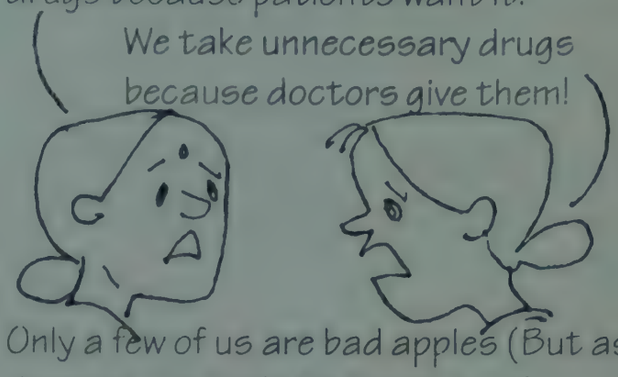
And now there are large number of medical colleges which charge Rs.15 lakhs for an admission : Which means another break - even analysis.



It is estimated that an honest government doctor cannot save up Rs.15 lakh profit even in a life time.

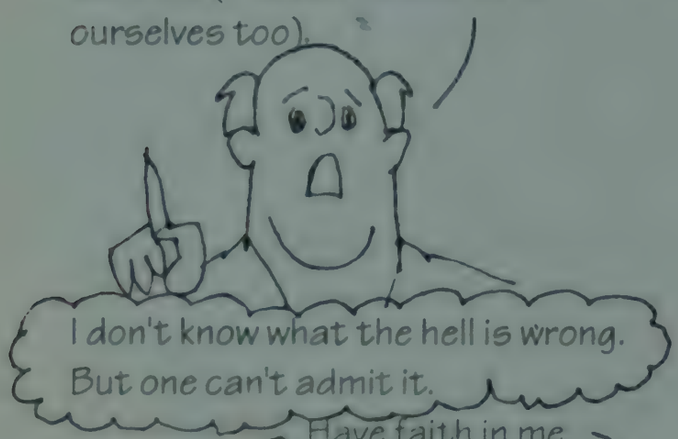
Whatever happened to the medical profession! And the doctor - patient relationships!

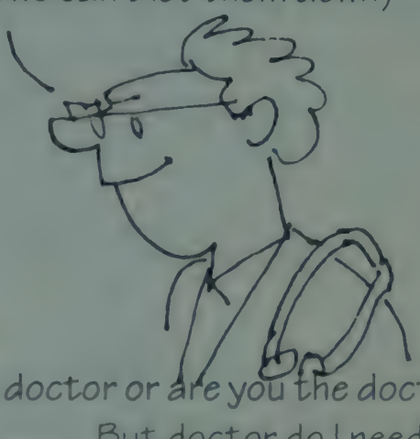


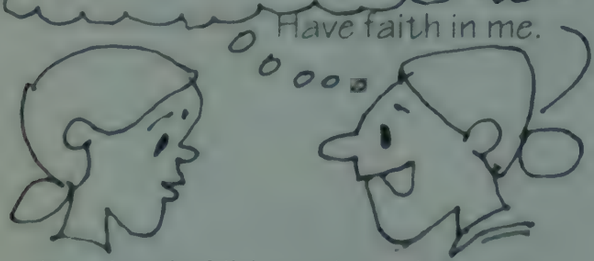


Non-doctors should not judge doctors (And we will not do it ourselves too).

Only a few of us are bad apples (But as doctors, we can't let them down)







Am I the doctor or are you the doctor?

But doctor do I need...

No thanks! I'd much rather go to homeopathy or Reiki or the neem leaf poojari.

Medical science has made tremendous advances.

Then why did my wife die

There's a crisis going within the profession.
But no one dares admit it .
The answers are not easy. Demystification and reform of the medical profession is the toughest nut to crack!

What is to be done ?

THERE IS NO ALTERNATIVE!

Till people learn
to demand health care

↓

And till we come to power.

↓

And we change the Economic Policies

↓

Till the medical profession is
listened to seriously by the Govt..

↓

And till there is a change of heart
in the profession.

↓

And Govt. can be made to do its
job and provide more funds!

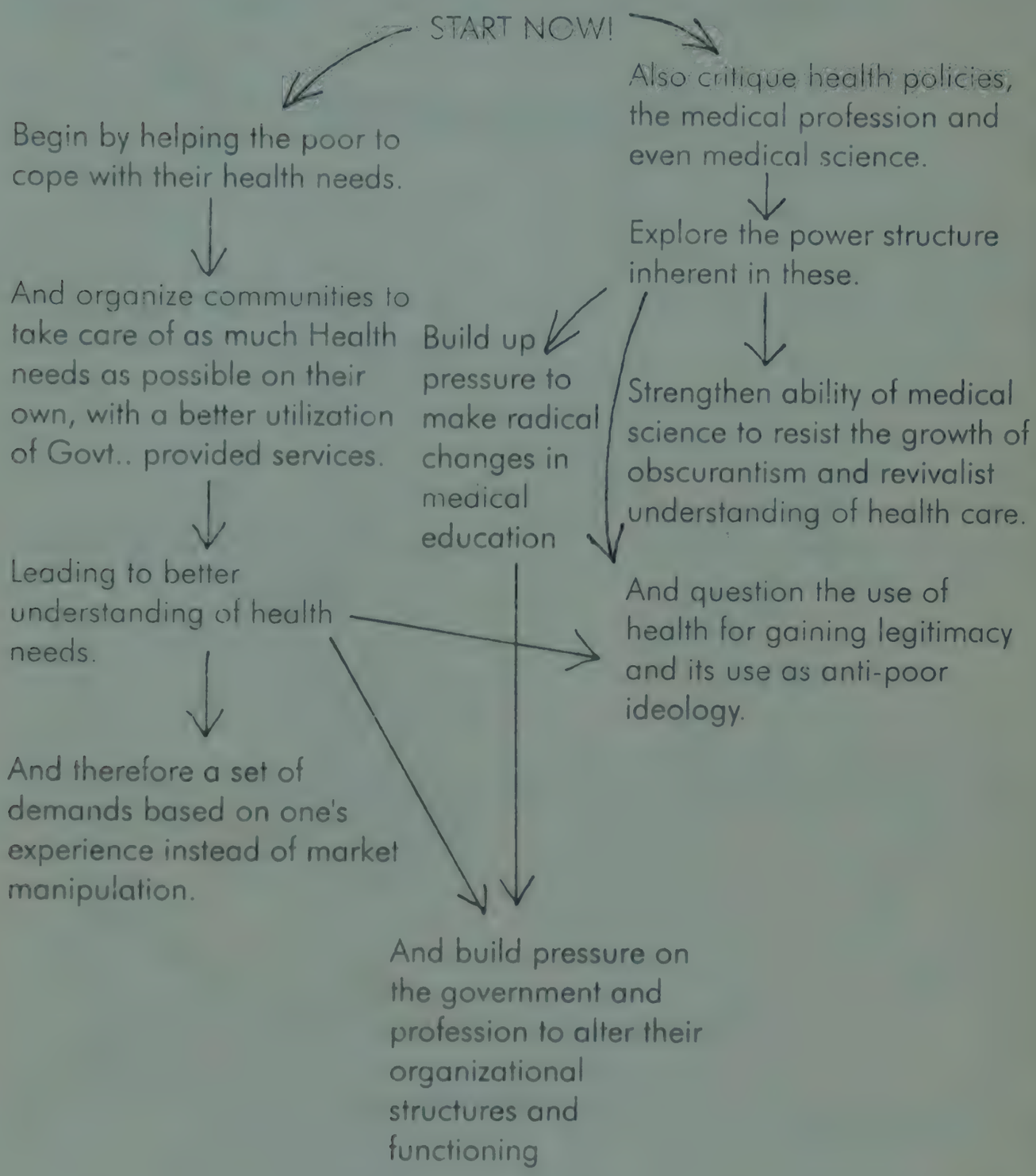
↓

NOTHING MUCH CAN BE DONE!

Except perhaps to voice the demands of the people and the professionals!

* But we have tried that for 50 years.
* What is to prevent people on coming to power using the health system for their own legitimacy?
* What is to prevent people's demands being shaped to suit corporate needs?

There is an alternative!



The goal is not:

- The capture of government, so that the new leaders may be legitimized
- But a revolution in health care as a part of a larger revolution in society!

> Medicine is a social science and politics is medicine on a large scale.
>
> *Rudolf Virchow, 1847*
>
> *Pathologist, one of the founders of modern medicine*

Begin at the beginning:

THE BASIC UNIT OF HEALTH CARE SHOULD BE A HABITATION (VILLAGE OR HAMLET, NORMALLY ABOUT 50 TO 200 HOUSEHOLDS). AT THIS LEVEL THE COMMUNITY ORGANIZES ITS OWN BASIC SERVICES.

What health services must be organized by the community for itself?

PREVENTIVE
* OPTIMAL USE OF RESOURCES & DEVELOPMENT OF SKILLS TO PREVENT MALNUTRITION.
* PROVISION OF SAFE DRINKING WATER AND TOTAL SANITATION.
* MUCH OF THE WORK INVOLVED IN PREVENTING SPREAD OF COMMUNICABLE DISEASES. (IN PARTNERSHIP WITH THE PHC)

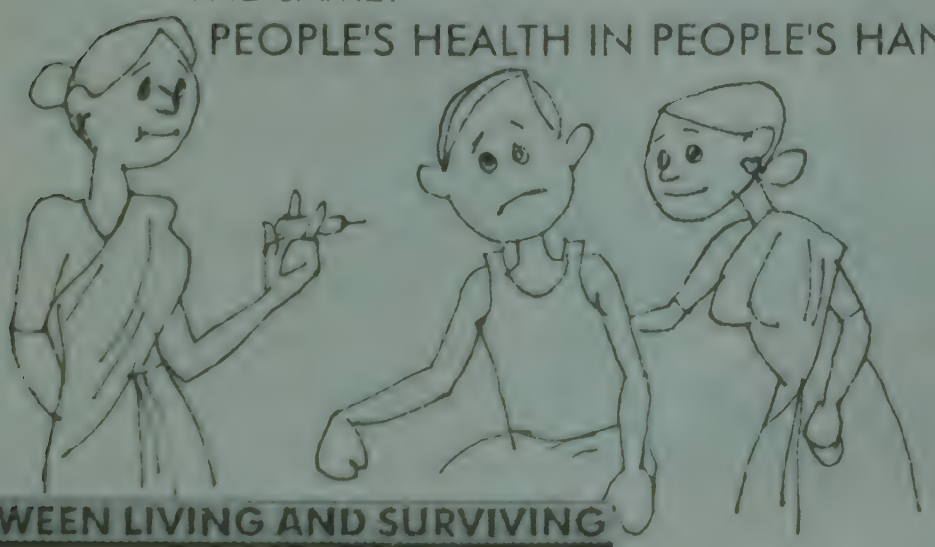
PROMOTIVE
* SPECIAL CARE FOR WOMEN AND WEAKER SECTIONS; ESPECIALLY FOR ADOLESCENT GIRLS AND PREGNANT WOMEN.
* FULL UTILIZATION OF PHC's SERVICES.
* BUILD UP SUPPORT INSTITUTIONS FOR WOMEN (CREDIT GROUPS, DAY CARE CENTRES, LEGAL AID ETC.)
* PREVENTION OF ADDICTIONS AND PROMOTION OF HEALTHY LIFE STYLE.
* ACCESS TO BIRTH SPACING METHODS.

CURATIVE.
* FIRST AID POST
* A DRUG AND MEDICAL SUPPLIES KIT WHERE ABOUT 30 DRUGS AND ESSENTIAL MEDICAL ITEMS SHOULD BE READILY ACCESSIBLE AT ANYTIME: (SUPPLIES FROM THE PHC)

TREATMENT OF MILD ILLNESS AND SYMPTOMATIC RELIEF - WITH INTEGRATION OF HOME REMEDIES AND HERBAL MEDICINES FOR THESE PURPOSES.

* REFERRAL LINKS TO THE PHC AND A REVERSE REFERRAL SO THAT PERSONS WHO NEED FOLLOW UP AND DAILY HELP (DRESSING, INJECTION ETC.) CAN BE PROVIDED THE SAME.

PEOPLE'S HEALTH IN PEOPLE'S HANDS'

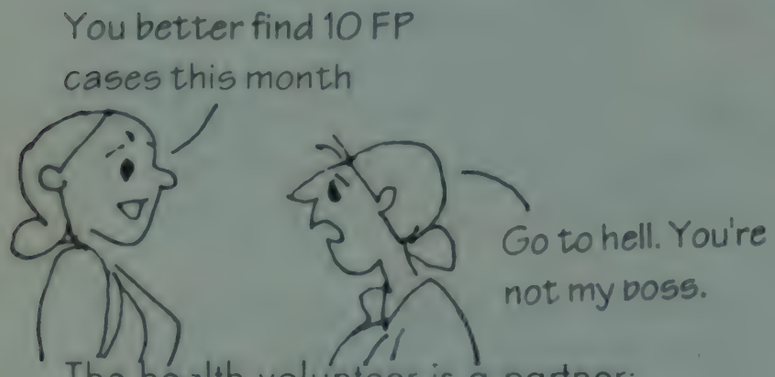


How is such community level care organised?

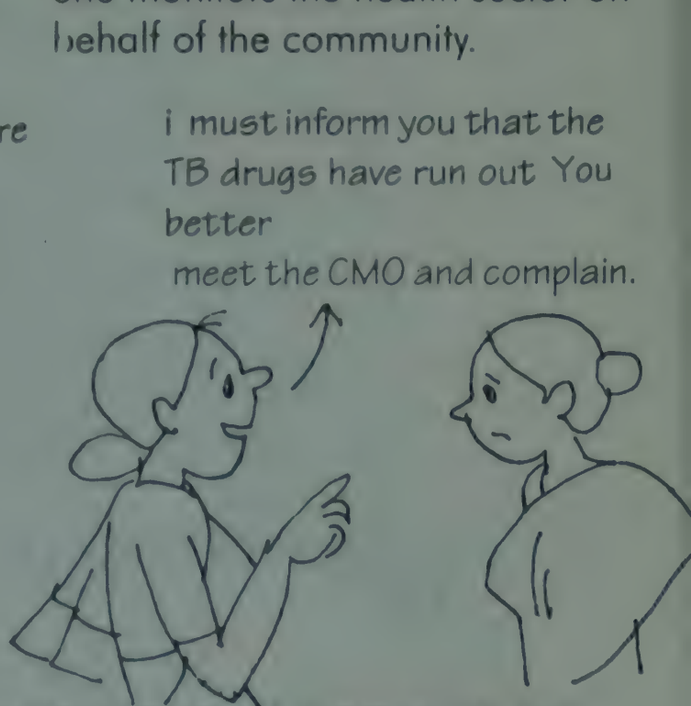
(a) Based on trained motivated volunteers selected by the community, enjoying its confidence and supported by it.
(b) A system of gathering health related information with which local priorities can be identified and effectiveness of intervention can be judged.
(c) Involvement of elected members and representatives of weaker sections in understanding health problems and its determinants and working out ways to solve them using technical help from outside.
(d) good cooperation in a spirit of partnership with the health department especially the sub-centre and PHC - to get facilities to help plan and inter vene at community and at the household level.
(e) Provision of training and support to the volunteers by a specially constituted, motivated group which understands that the community is not homogenous and is committed to empowering the weaker sections.
(f) Weaker sections by caste, class and gender are to be organized or their existing organizations linked to this programme.

How is community level care NOT organized

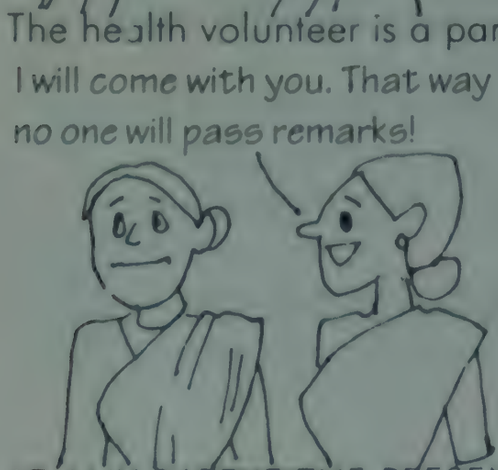
The health volunteer is not
an appendage of the health pyramid.



She monitors the health sector on behalf of the community.



The health volunteer is a partner:



AT ANY RATE IF THE PRESENT HEALTH DEPARTMENTS ORGANIZE THE COMMUNITY - NOTHING WILL HAPPEN - OR WORSE

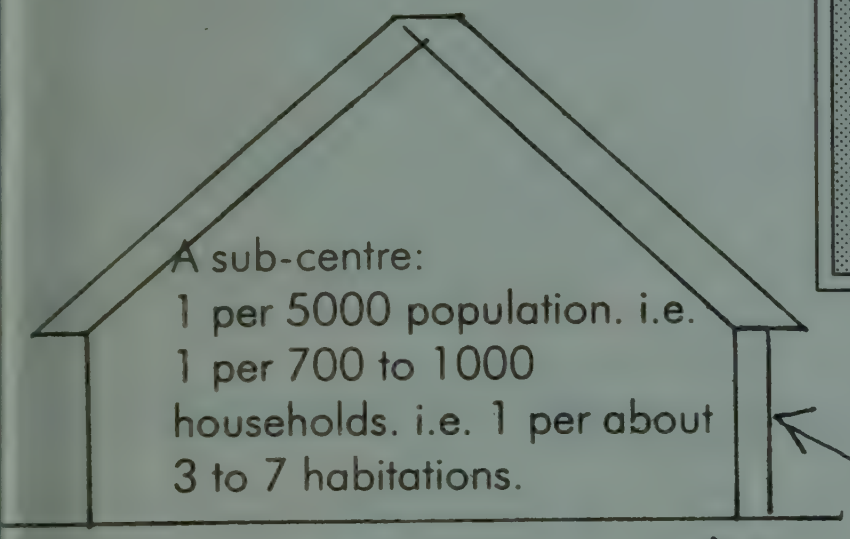
Nor can it be left to spontaneity. Organizing the community must be done only by democratic groups, people's movements and NGOs and others committed to the cause of weaker sections.

Ensure functional sub-centres:

The key to public health is the development of the Multipurpose health worker (female) also called village health nurse as the effective dynamic centrepiece of the system.

> Thailand and Malaysia have half as much doctors (per capita) as we have and much better health outcomes. But they have three times as many nurses as we have! The number of nurses correlates much better with eventual health outcomes.

FOUR ELEMENTS OF SUCCESS!



THE HARDWARE

A good sub-centre building. A good accommodationfor the MPW.

Basic drugs and medical supplies available. A moped or cycle for mobility.

THE SUPPORT

Functional community, village level units which act as her partners - especially health volunteers who work with her (but not under her).

Good support from local leaders and organizations especially those representing weaker sections.

Ensure local accountablity.

THE SOFTWARE

-Create skills and ability in her to understand and respond to local health needs - instead of her having to impose centrally fixed package of services on an unwilling population.

- constant retraining.

THE HUMAN COMPONENT

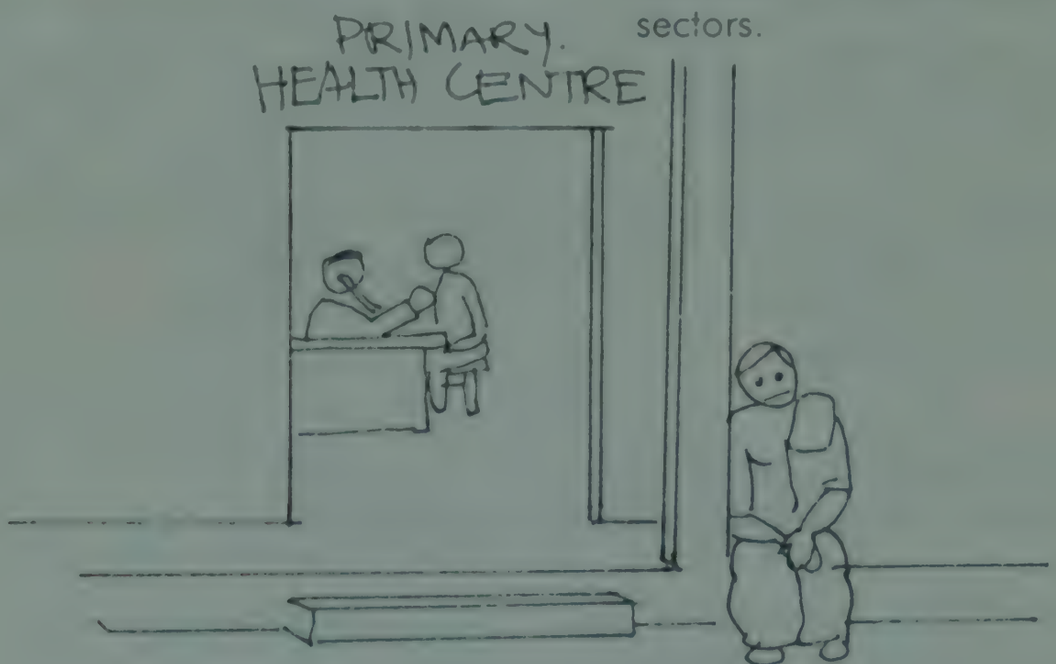
* Select, post and transfer as far as possible within the district.
* Grievances committee for protection against harassment especially sexual harassment.
* Adequate wages paid on time with a good benefit package for child care and education.
* Better morale by better administrative support. Stop making her a scapegoat of her for all of the health system failures.

THOUGH THE GOVT IS COMMITTED TO PROVISIONING THIS, MUCH OF THIS MAY BE ENSURED ONLY BY COMMUNITY AND PANCHAYAT'S INITIATIVES.

An effective primary health centre.

Basic minimum.

1. A building with a laboratory, consulting room and a 4 to 10 bed ward, a minor OT where minor surgeries can be done, and delivery can be conducted.
2. Adequate stocks of drugs and about 60 essential drugs and medical supplies.
3. Transport to convey sick patients and referrals to the block or district hospital.
4. Essential services available 24 hours a day, at least with trained nurses, where doctors are not possible.
Minimum staff: Must include 2 medical officers, 2 to 4 nurses or multipurpose workers and pharmacists, lab. technician etc..
5. Must provide support to village level basic units and to the 6 sub-centres.
6. Must have all the services needed to address local health priorities. Needs to have the ability to assess and plan for it.
7. Good two way links with block and district hospital for
    * referring complicated cases.
    * getting more specialized investigations done.
    * getting a specialist's opinion and good communication facilities to facilitate this.
8. Supervised by a committee with local elected representatives.
Coordination of PHC with water and sanitation, nutrition and other sectors.



The taluk or block level hospital

(1 per about 1 lakh population)

At this level a good curative centre is essential. Such a centre will have:
* a hospital with 50 beds at least!
* all basic diagnostic and treatment including blood transfusion unit and surgical facilities, especially for obstetric emergencies.
* A team of 7-10 doctors.
* an epidemiological team to assist in health and disease assessment, surveillance and planning.

Is it possible ? What about the costs ?

The national need is for about 9000 such block level hospitals, linked to about 40,000 PHCs and about 2,40,000 sub centres.
That would be an increase in budget outlay (to atleast: 6 percent of the budget). One can also contain costs by:
a) Lowering top heavy administrative expenditure and inefficient vertical programmes.
b) Eliminating corruption.
c) Insisting on rational drug therapy and rational treatment protocols.
d) Seeking community support especially at the village unit level (fully by communities) and at sub-centre level (partly by community)

With the considerable international funding available today if the political will is there - this is possible - today! If one is able to restructure our economic policies such resources could be available even within our own country!

District Hospital

For the poor, for serious sickness this is the only facility available today! No wonder it is so overcrowded.

THE ONLY WAY TO MAKE THE DISTRICT HOSPITAL WORK IS TO MAKE THE PHC & BLOCK HOSPITALS FUNCTION.

ONLY cases referred by PHCs and Taluk hospitals or by private doctors may be seen. (Today this would be unacceptable as PHCs do not work)

* ONLY difficult and complicated cases are referred to the district hospital. After diagnosis and starting the treatment they are referred back to the PHC or block hospital or private doctor for further follow up.
* One can save considerable costs by following rational diagnostics and treatment protocols!
* THE DISTRICT HOSPITAL MUST HAVE ALL THE SUB-SPECIALITIES AND MODERN DIAGNOSTIC FACILITIES NEEDED!
* AND NO PRIVATE PRACTICE FOR ANY GOVERNMENT DOCTOR!
* THE DISTRICT IS THE APEX WHERE HEALTH INFORMATION IS ANALYSED, HEALTH PLANS ARE FINALIZED AND RESOURCES ARE ALLOCATED ACCORDING TO PRIORITIES.

Note: These suggestions are not new, they are well accepted suggestions. They form port of the national health policy recommendations. What is needed is a serious attempt to implement it. At the community level, and sub centre level it is social mobilisation and organization that is the key. At higher levels - PHC level, block and district level, adequate public demand needs to build up to implement these measures.

What is the function of state and national capitals?

Decentralisation of health services does NOT mean lack of responsibility of state and national centres.

Planning at local levels does NOT mean absence of planning at state and national capitals:

The State and national centres must

a) Provide a policy framework that supports decentralisation.
e.g.: More powers to the Panchayats.
Accountability of health employees to elected bodies at that level.
Provide more financial resources to Panchayats.

b) Provide administrative mechanisms to support and facilitate community initiatives.
e.g.: Co-operate with people's initiatives and NGO's who build community organisations and train community health workers.
Establish referral linkages between health worker and PHC's. Extend basic drug availability to such workers etc.
Provide technical support to local planning initiatives.

c) Intervene to prevent uneven development & ensure social justice.
e.g.: Certain tribal & backward areas may lag behind. More funds & support to such areas are needed.
Weaker sections which may be minority group locally may be left out or be treated equally, when to redress inequality they merit preferential treatment. States need to intervene in such situations.

d) Ensure minimum equality standards.

Where decentralised planning & local initiatives fail to ensure a minimum health status outcome, the state needs to step in for corrective measures and to build capabilities. To be able to do so there must be autonomous bodies that monitor health and disease status so that early warnings are sounded & interventions can be planned.

e) Ensure adequate production & proper distribution of pharmaceuticals & biological products like vaccines at non-monopoly costs.

f) Ensure a sound policy for expansion of medical research and quick access to expertise for health planners and administrators.

g) Ensure that health manpower development quantitatively and qualitatively matches the community needs.
This last is one of the most difficult of tasks.

Change in the Profession

Immediate measure: Stop capitation fee based medical colleges.

Immediate measure: Disengage private practice from the public health system beginning from teaching hospitals and then moving on to district hospitals and block hospitals.

Medium term measures: Strengthen regulation measures in private practice, especially on corporate practice. No regulation measure exclusively by doctors or exclusive of doctors.

Medium term: Exclude commercial interests with strict regulation ofpharmaceutical & health industry's marketing strategies & ensuring transperency

Medium term: involve the profession in continuing medical education that constantly reorient them & involve them in public health & community action. Build up groups within profession who are committed to its reform.

Medium term: More information to public on costs & nature of health care with easy opportunity to cross check costs. More involvement of community in health care & more accountability of profession to the community it serves.

Long term measure: Radical restructuring of medical education & the way the profession is constituted.

Long term measure: Critically re-examine medical science. Admit its uncertainties and its inconsistencies. Integrate with other systems. Develop it informed by insights from social sciences.

TRANSFORMING THE MEDICAL PROFESSION.

Upgrade skills of village level health care providers: dai, RMPs, hakims, vaidyas.

Involve local health care provides in preventive and promotive work.

Provide forums to systematically share and build on knowledge bases of indigenous medical system.

Work to validate truth-claims of different systems while understanding their frameworks & limitations of existing methodologies.

Evolve regulatory system as part of restructuring of medical education.

THE HEALTH CARE PROVIDERS

But victory can not be assured!

For there are forces at work in both directions!

The power of the medical profession and the health industry is too much to resist easily.Politicians, industrialists, successful doctors and other privileged sections often support private medical colleges and corporate hospitals as it serves their interest!

Why, a transport workers union has now opened a medical college, so that worker's children can become doctors! Of course ask them to provide health services for their own colleagues involved in accidents and they would refuse - It's the government's job!

These trends are symptoms of a dangerous new culture that is afoot and shows how perception of what needs to be done for improving health has got warped. How often the agenda of change is subverted by the agenda of jostling for a better position for oneself or for a small section within the existing setup!

The campaign for an effective health system can not withstand these forces in isolation.

It must join forces with:

a. Campaigns and movements against poverty: against inequalities of property and power.

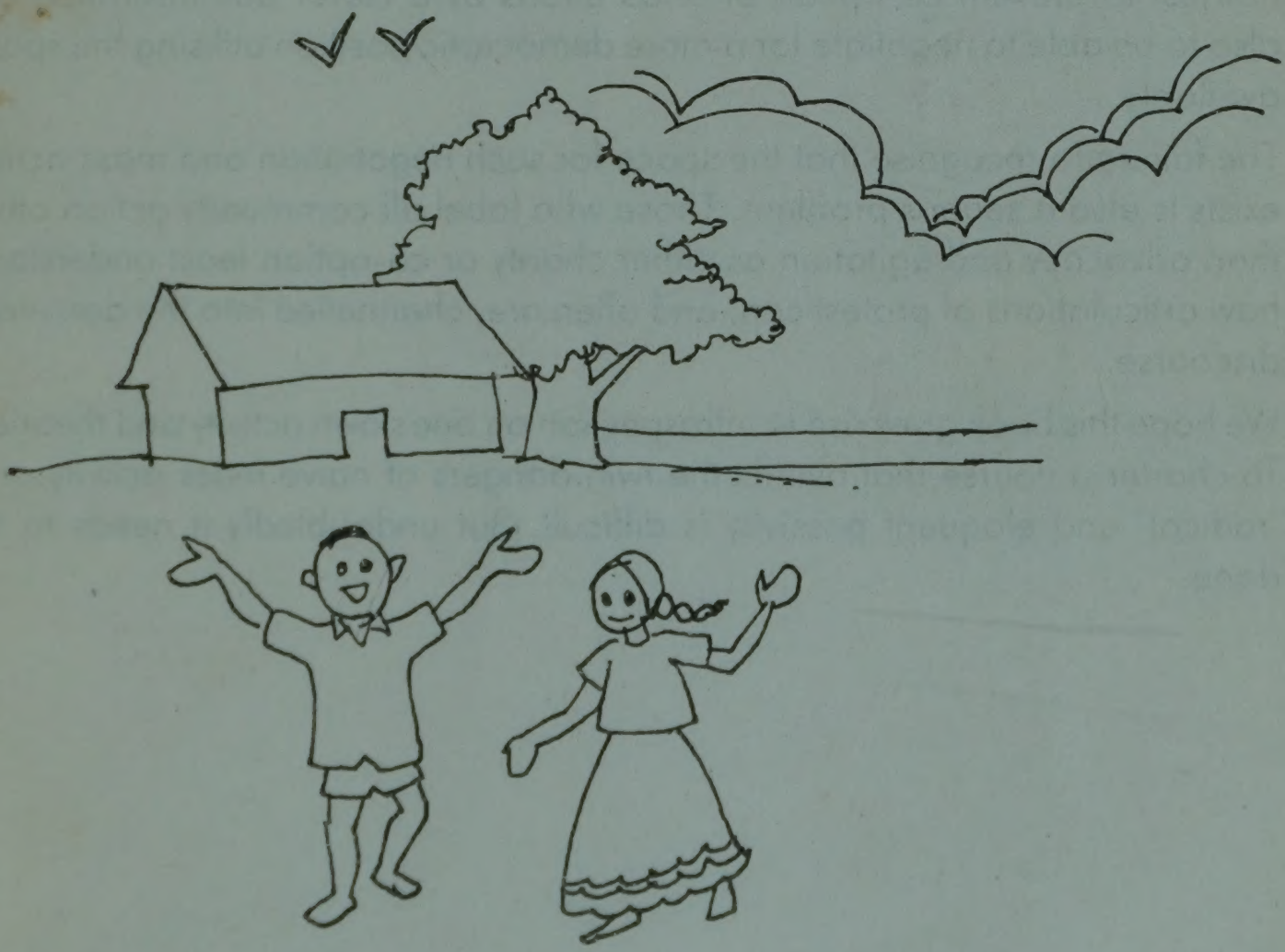
b. Campaign for better living conditions: environmental movements, for better housing, movements for basic facilities like drinking water and sanitation.

c. Campaign for better working conditions: Movements whose goal is that control over productive process is democratized.

d. Campaigns against patriarchy and other discrimination: Women's movements and feminist movements and democratic movements that oppose the discrimination against women and discrimination based on caste, ethnicity.

e. Cultural movements - that question today's accepted values, standards and norms. Movements that express the anguish of the human condition - impoverished and oppressed, yet optimistic.

f. Broad movements for sovereignty, so that health plans are decided in India and not in the anonymous back rooms of the WORLD BANK!



A Post Script

This book is addressed primarily to the people's science movement activist; But we hope this book is of interest to all those working in health movements and in democratic .novements, who feel the need to relate their immediate preoccupations - the urgency of reaching out to the sick and disempowered - with the larger goal of a more equitable and prosperous nation.

This book is a part of a series being brought out by the All India People's Science Network and the Bharat Gyan Vigyan Samithi to mark the 50th year of India's Independence. This commemorative series addresses the concern that even as the golden jubilee celebrations are on, much of the values and goals that inspired our struggle for independence are being undermined by the rising tides of globalisation and corruption.

In the realm of economic policy the break with our earlier priorities is overt and loudly proclaimed. But as the provision of health care is a major vehicle for legitimising a modern state, the changes in health policy are presented as continuation or implementation of our past commitment of the conception of health as a fundamental right (Bhore Committee, Alma Ata declaration etc.)

To the activist in the field, the difference between health as a fundamental right and the `health as a safety net' concept may not appear to matter so long as both leads to some effective care for the poor. But our experience has shown that grasping this difference is crucial to people's movements. This is not just to prevent co-option of one's efforts by a clever administration but also to be able to negotiate for a more democratic position utilising the space available.

The failure to recognise that the space for such negotiation and mass action exists is also a serious problem. Those who label all community action other than advocacy and agitation as either charity or co-option least understand how articulations of protest can, and often are, channelled into the dominant discourse.

We hope this book gives rise to introspection on one's own activity and theories. To charter a course that avoids the twin dangers of naive mass activity or a "radical" and eloquent passivity is difficult. But undoubtedly it needs to be done.